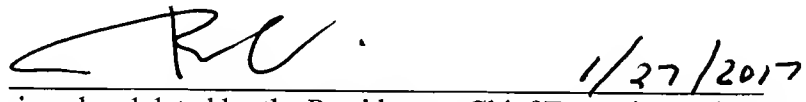
Certificate of Need Application Form
Version 09.2016

Name of Applicant	Prime Healthcare Services – Landmark, LLC
Title of Application	Establishment of a Level III Designated Trauma Center
Date of Submission	
Type of review	__X___ Regular Review _____ Accelerated Review (provide letter from the state agency) _____ Expeditious Review (complete Appendix A)
Tax Status of Applicant	_____ Non-Profit __X___ For-Profit

Pursuant to Chapter 15, Title 23 of The General Laws of Rhode Island, 1956, as amended, and Rules and Regulations for Determination of Need for New Health Care Equipment and New Institutional Health Services (R23-15- CON).

All questions concerning this application should be directed to the Office of Health Systems Development at (401) 222-2788.

Please have the appropriate individual attest to the following:
"I hereby certify that the information contained in this application is complete, accurate and true."



1/27/2017

signed and dated by the President or Chief Executive Officer

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PROJECT DESCRIPTION AND CONTACT INFORMATION

1.) Please provide below an Executive Summary of the proposal.

Landmark Medical Center (LMC) is proposing to establish a certified Level III Trauma Center as defined by The American College of Surgeons (ACOS)[1]. Certification and operation of this program requires modification to the hospital's existing emergency facilities to meet applicable ACOS standards and accommodate additional projected volume. Facility improvements are needed to expand work areas, improve workflows and facilitate coordination of staff. The proposed project will enable the establishment of the new trauma program while simultaneously preparing LMC's Emergency Unit ("EU") facilities to meet the needs of the future.

The hospital is requesting approval to spend $11,286,500 for these purposes.

Trauma

According to the National Trauma Institute (NTI), "each year trauma accounts for 41 million emergency department visits and 2.3 million hospital admissions across the nation." It is the first leading cause of death in the United States for persons aged 46 and younger and third leading cause of death overall. Almost 200,000 persons die from medical trauma each year.[2]

Trauma is defined as a major medical condition that arises suddenly from an external cause (e.g., accident, injury) as opposed to an illness resulting from an internal, underlying disease process (e.g., heart disease or cancer). Medical trauma frequently leaves victims medically unstable and poses the threat of imminent death or grave disability. Trauma injuries generally result from specific events such as auto accidents, burns, falls, acts of violence and similar incidents. Because trauma is not caused by a natural disease process, treatment requires special knowledge and resources not typically available at all acute care facilities.

Fewer than one in five U.S. hospitals are certified to provide trauma care. Certification requires compliance with the ACOS's programmatic and resource guidelines for trauma care. The Committee on Trauma (COT) of the ACOS maintains these guidelines on an ongoing basis and conducts constant surveillance over trauma centers to ensure they maintain their qualifications and performance. Certified Trauma Centers are also "designated" by units of local government to ensure public awareness of their role in emergency response situations.

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[1] *www.facs.org*

[2] *The source of statistics cited in this paragraph is the current home page of the National Trauma Institute (nationaltraumainstitute.org).*

Health officials urge that a Designated ACOS Trauma Center (DTC) be the service of first resort for the care of trauma victims whenever possible. In many jurisdictions rescue services are required to immediately transport acute trauma cases to the nearest trauma-qualified facility if practicable. The goal of such policies is to minimize time-to-treatment for trauma victims and optimize outcomes. The success of such policies obviously depends on the geographic availability of DTC's.

In order to promote the geographical dispersion of trauma care, policy makers have developed an interconnected network of trauma facilities that vary by degrees of capability and sophistication. Each Center is certified by ACOS according to a system of "Levels", i.e., from "Level 1" (most robust) to "Level 5" (least sophisticated.) This stepwise approach allows for a more broadly accessible network of trauma care access points while relying on rapid clinical stabilization and transport of victims from centers of lesser to greater capability as necessary.

While far from ideal, this approach does enable access to trauma treatment more quickly than might otherwise be possible. This is particularly true in cases where Level I-III DTC's are readily available. In practice, the capabilities of Levels IV & V DTC's are not well distinguished from those of standard non-certified hospital EU's and are not considered to be trauma centers for practical purposes. Hence these "lower level" trauma centers are not as dependably valued.[3] (For the purpose of this Application, the terms "designated" or "certified" typically refers only to Levels I-III.) Often, therefore, when a Level I-III DTC is not readily accessible, care is sought at the closest acute hospital EU – regardless of trauma designation. In 2013, for example, roughly 45% of all trauma cases in the U.S. were unable to obtain treatment at Level I-III trauma EU's.[4] Therefore, while there have been consistent efforts to create an extensive trauma care system, appropriate treatment is frequently beyond the reach of many trauma victims:

> "Most Americans assume that if they're in a car wreck or another severe injury befalls them, an ambulance will arrive quickly and whisk them away to a hospital that can handle their particular condition. But in many places that assumption would be wrong."
>
> "Nearly 45 million Americans do not have access to a Level I or Level II trauma center within the "golden hour" after they are injured, according to 2009 Centers for Disease Control and Prevention data. Although most injuries can be handled at a local emergency department, treatment of severe injuries at a Level I trauma center lowers the patient's risk of death by 25 percent."

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[3] *Typically, trauma surveillance systems such as the National Trauma Database and the broader DHHS Hospital Utilization and Cost Project, HCUP, make little, if any effort, to include Level IV & V DTC's in their data.*

[4] *See footnote 6*

> "To close the gaps, many states either have developed statewide trauma systems over the past decade or are in the process of creating them. However, "the overall landscape across the United States is islands of excellence surrounded by large portions of our country where injured patients don't have access to a trauma system," says A. Brent Eastman, M.D., chief medical officer of Scripps Health in San Diego and chair of trauma at Scripps Memorial Hospital La Jolla."[5]

According to the National Trauma Database, patients diagnosed with trauma are identified by the range of ICD-9 diagnostic codes running from 800 to 959.[6] Virtually all trauma cases are diagnosed in this range and enter the acute care system through hospital emergency rooms. While many of these cases are determined to be mild or non-life threatening, this determination often cannot be made until a patient has been appropriately assessed and diagnosed at a DTC. Prior to such assessment, first responders seek to err on the side of caution. For this reason, many more trauma patients visit emergency rooms than are admitted for inpatient trauma treatment. It is important to note that one of the main functions of a trauma center is to rapidly distinguish between truly life-threatening injury and lesser forms of trauma.

As a Level III Center, the role of the proposed program will be to provide rapid assessment and stabilization of the victim and ongoing treatment if capabilities permit. If more specialized treatment is required, but unavailable at LMC, patients will be stabilized then speedily transferred to a Level I or Level II facility. The proposed program will establish and maintain ongoing consultation and transfer processes with facilities having both lesser and greater capabilities and will serve as an extension of, or "entrance to", Levels I & II Centers in the area – especially the Level I Trauma Center at Rhode Island Hospital, located in Providence. A copy of the Transfer Agreement with Rhode Island Hospital is included at Exhibit 1 as are draft stabilization and transfer policies when a higher level treatment is required. As required by the ACOS Guidelines (defined below), LMC's Trauma Team (defined below) will review and modify these policies prior to implementation.

The Applicant has proposed the development of a Level III ACOS Certified Trauma Center. To obtain ACOS certification, the proposed program must meet guidelines developed by ACOS, Committee on Trauma Care (COT) ("ACOS Guidelines"). The ACOS Guidelines are discussed below.

ACOS Guidelines

The development of an ACOS Trauma Center is a comprehensive undertaking that requires participation and coordination of multiple hospital departments as well as establishment and management of multiple community/institutional relationships. Certification requires compliance with over three hundred specific guidelines

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[5] *Closing the Gaps in the Nation's Trauma System - Hospitals and Health Networks Magazine, October 2012*

[6] *Velopoulos et al., National Cost of Trauma Care By Payor Status, Journal of Surgical Research, Johns Hopkins, June 10, 2013.*

developed by ACOS. While the ACOS Guidelines apply in varying degrees to the different levels of Trauma Care (I-V), over 80% of them apply specifically to operation of the Level III DTC as proposed.

The ACOS Guidelines are described in the 221 page publication: Resources for Optimal Care of the Injured Patient, 2014. The "quick reference guide" as to the ACOS Guidelines is included at Exhibit 1. Approval of a new center typically requires additions and changes to a wide range of hospital activities and services. These impact hospital management and governance, medical staff functions, delivery of certain clinical services and other activities such as performance improvement, education, outreach and prevention. Such changes require development of a new management infrastructure within the hospital that includes a Medical Director for Trauma, a Trauma Program Director, and several new or expanded functions such as a Trauma Registrar, trauma educators and coordinators for various trauma related processes.

Given the complexity, urgency and multidisciplinary nature of Trauma Care, a certified center must function with an uncommon degree of independence and deference within an existing hospital. The ACOS Guidelines demonstrate this need in several ways. They require, for example, that trauma program administrators have special relationship with governance and medical staff leadership: "A decision by a hospital to become a trauma center requires the commitment of the institutional governing body and the medical staff. The commitment and collaboration of these two bodies are necessary to facilitate the allocation of resources and the development of programs designed to improve the care of injured patients." (ACOS Guidelines, pg. 34).

Another aspect of special status is the need for certain generic processes or pre-existing policies to be developed more specifically to meet the needs of the Trauma Center and that the Trauma Team have a clear role in their development. A good example of this is demonstrated by the ACOS guidance on the development of patient transfer agreements: "These guidelines and agreements for trauma patient transfer are not the classic transfer agreements of the past.....These guidelines and agreements should be crafted with the full support of trauma center administration and leadership" (ACOS Guidelines, Chapter 4, pg. 30).

The development of protocols and training for the pre-hospital phase of trauma care must be handled directly by the actual Trauma Team itself. According to the ACOS Guidelines, these "must be established by the trauma health care team, including surgeons and emergency physicians working directly with community agencies such as "medical directors for EMS agencies", and other "basic and advanced prehospital personnel" (the "Trauma Team" per ACOS Guidelines, pg. 24).

These examples demonstrate that the operation of the trauma program and its relationships (both within the hospital and within the broader community) must be developed by or with the direct participation of the Trauma Team and its leaders. As stated squarely in the ACOS Guidelines, "The Trauma Medical Director must have the

authority to manage all aspects of the trauma care" at the hospital (the ACOS Guidelines, pg. 37).

While LMC must achieve ACOS approval, its efforts to engage staff and develop the program will be limited prior to CoN approval. Although existing staff are presently working towards the development of the center, LMC is not yet in the position to recruit for key positions such as Trauma Medical Director or Program Director and others as well. The development of specific processes such as definitive transfer agreements and other protocols will be the job of the Trauma Team once it is in place and begins to prepare for the certification, inspection and initiation of operations. Once all the necessary processes and policies are developed in final form they will, by necessity, comply with the ACOS Guidelines in every respect. This will be necessary in order to obtain certification.

Improved Access to Trauma Care

As noted above a large percentage of patients requiring specialized trauma care do not dependably receive it. The proposed project is designed to make DTC services more accessible to a substantial geographic area encompassing portions of Rhode Island and nearby Massachusetts - an area of almost 1,000 square miles. At present there are no Level I–III Trauma Centers located within this area. Patients must travel to facilities in Boston, Worcester and Providence. Travel studies show that LMC's location provides distinct advantages in time-to-treatment for trauma cases arising within the target area.

As a Level III facility, the proposed project will assure that more trauma patients obtain timely assessment, stabilization and rapid initiation of care at LMC or at a facility with greater capabilities as necessary. That is, even for many of those patients who will require transfer elsewhere for definitive treatment, LMC will provide the fastest path to stabilization and the greatest assurance of an optimal outcome.

As noted above, nationwide statistics demonstrate that a very substantial percentage of trauma victims lack ready access to a DTC. The Applicant believes that there is a large unmet need for these services within the proposed target area. The goal of the proposed program is to improve access to trauma care and reduce this unmet public need.

The Proposed Facility Modifications

As described more fully below, Trauma Centers provide both Emergency Unit and Inpatient Services. Given the nature of trauma care, only about 10-15% of all patients presenting for assessment and diagnosis actually require extensive inpatient care. For this reason, the development of a trauma center requires adequate, state of the art emergency facilities in addition to robust inpatient resources. The Applicant projects that its emergency unit volume will substantially increase with the implementation of this project. For this reason, this proposal includes expansion of current EU capacity

and reorganization of work-flows to accommodate efficient provision of Level III trauma care.

This project also includes an increase in operating costs of $5,763,000 per year for the additional staffing and other resources necessary to comply with ACOS requirements for Level III Trauma Care.

Timeframe

The implementation of the proposed project is expected to begin upon approval of this CoN request and requires 18 months for completion. The proposed program is scheduled to commence operations in January, 2019.

2.)

Capital Cost	$11,286,500	From responses to Questions 10 and 11
Operating Cost	$5,763,000	For the first full year after implementation, from response to Question 18
Date of Proposal Implementation	January/2019	Month and year

3.) Please provide the following information:

Information of the applicant:

Name:	Prime Healthcare Services-Landmark, LLC	Telephone #:	(401) 769-4100
Address:	115 Cass Avenue, Woonsocket, RI	Zip Code:	02895

Information of the facility (if different from applicant):

Name:	Landmark Medical Center	Telephone #:	(401) 769-4100
Address:	115 Cass Avenue, Woonsocket, RI	Zip Code:	02895

Information of the Chief Executive Officer:

Name:	Richard Charest	Telephone #:	(401) 769-4100 x2000
Address:	115 Cass Avenue, Woonsocket, RI	Zip Code:	02895
E-Mail:	rcharest@primehealthcare.com	Fax #:	(401) 766-5488

Information for the person to contact regarding this proposal:

Name:	Cynthia J. Warren, Esquire	Telephone #:	(401) 331-5700
Address:	301 Promenade Street, Providence, RI	Zip Code:	02908
E-Mail:	cwarren@cm-law.com	Fax #:	(401) 454-4526

4.) Select the category that best describes the facility named in Question 3.

[ ]	Freestanding ambulatory surgical center	[ ]	Home Care Provider
[ ]	Home Nursing Care Provider	[X]	Hospital
[ ]	Freestanding Emergency Care Facility	[ ]	Hospice Provider

[ ] Inpatient rehabilitation center (including drug/alcohol treatment centers)

[ ] Multi-practice physician ambulatory surgery center

[ ] Multi-practice podiatry ambulatory surgery center

[ ] Nursing facility [ ] Other (specify): _____

5.) Please select each and every category that describes this proposal.

A. ___ construction, development or establishment of a new healthcare facility;
B. _X_ a capital expenditure for:
   1. ___ health care equipment in excess of $2,451,805;
   2. _X_ construction or renovation of a health care facility in excess of $5,720,877;
   3. ___ an acquisition by or on behalf of a health care facility or HMO by lease or donation;
   4. ___ acquisition of an existing health care facility, if the services or the bed capacity of the facility will be changed;
C. ___ any capital expenditure which results in an increase in bed capacity of a hospital and inpatient rehabilitation centers (including drug and/or alcohol abuse treatment centers);
D. ___ any capital expenditure which results in an increase in bed capacity of a nursing facility in excess of 10 beds or 10% of facility's licensed bed capacity, which ever is greater, and for which the related capital expenditures do not exceed $2,000,000
E. _X_ the offering of a new health service with annualized costs in excess of $1,634,536;
F. ___ predevelopment activities not part of a proposal, but which cost in excess of $5,720,877;
G. ___ establishment of an additional inpatient premise of an existing inpatient health care facility;
H. _X_ tertiary or specialty care services: full body MRI, CT, cardiac catheterization, positron emission tomography, linear accelerators, open heart surgery, organ transplantation, and neonatal intensive care services. Or, expansion of an existing tertiary or specialty care service involving capital and/or operating expenses for additional equipment or facilities;

HEALTH PLANNING AND PUBLIC NEED

6.) Please discuss the relationship of this proposal to any state health plans that may have been formulated by the state agency, including the Health Care Planning and Accountability Advisory Council, and any state plans for categorically defined programs. In your response, please identify all such priorities and how the proposal supports these priorities.

The proposed project addresses several issues of importance to health policy as identified by various studies and policy statements formulated by the state agency and the Health Care Planning and Accountability Advisory Council -- including state plans for categorically defined programs. These are enumerated as follows:

a. **<u>The 2013 Report to the General Assembly; Health Care Planning, Accountability and Advisory Council</u>**

This document reports the results of an extensive study of the "future supply and demand for inpatient care" in Rhode Island. Among the report's findings is concern for the decreasing use of such services, the related drop in occupancy rates at hospitals and the resulting financial implications.

> "In Rhode Island, falling inpatient utilization combined with steady-to-rising bed supply has led to declining occupancy rates and potentially excess supply of beds."- Pg. 9

> "The savings associated with eliminating excess inpatient capacity in the most likely scenario range from about $12M, when only incremental costs are considered, to more than $100M when all hospital costs are eliminated."- Pg. 4

The Report to the General Assembly identifies net changes in migration of patients across state lines as one of the key drivers of decreasing utilization. This factor has historically benefited Rhode Island given the favorable difference between the number of "imports" (patients in-migrating) and the number of "exports" (out-migrating). Close examination of more recent data in the preparation of this report has revealed a softening of this phenomenon:

> "Net Migration: Overall, more patients from other states come to Rhode Island for hospital care than Rhode Islanders go to other states for care. <u>However, the gap is narrowing</u>." – Pg. 4

While the migration factor is only one of several factors affecting hospital performance in Rhode Island, its influence is relatively large in relation to others. The report finds in fact that improvements in hospital occupancy are the tactic most likely to have the greatest positive impact on the cost and stability of inpatient services in Rhode Island (Pg. 9).

It should be noted that much of the target area for the proposed project includes the populations of several cities and towns in Massachusetts. As is

discussed further below, analysis of travel times for trauma treatment for residents of these towns confers substantial advantages for a DTC located at LMC. This is also true for many of the RI locales traditionally forming LMC's Primary Service Area. These factors indicate that the proposed program will attract many patients to Rhode Island who must presently rely on facilities in Worcester or Boston for Trauma Care and in turn increase in-migration of patients to RI. At the same time, it will likely have some impact on out-migration as well. This double impact will improve net-migration of patients in favor of Rhode Island and obviously help to improve the average occupancy rate for acute care.

It's worth commenting that this approach to the occupancy rate concern is preferable to obvious alternatives. That is, occupancy can be increased either increasing appropriate admission for acute care or diminishing bed capacity through service reductions and layoffs. While both options may be necessary, the first undoubtedly makes for a more stable and more robust system of general hospital services. Given these factors, the Applicant believes that the proposed project will make an important contribution to the achievement of policy goals for the health care services in Rhode Island.

Another factor in the decline of hospital utilization according to The Report is the flat growth rate of the state's population. This decline is particularly meaningful when considered in conjunction with another unsettling trend identified in The Report:

> "Analysis demonstrates that not only has the state's population fallen since 2008, (but) residents are using fewer inpatient services per person (Figure 1), leading to quickly declining inpatient volume.- Pg-8

The Applicant projects that roughly 60% of the users of the proposed program will be MA residents. While this does not change the growth rate of the RI population, it does expand the base of users of the RI acute care system. That is, it attracts both patients and associated revenues from our neighboring state into our acute care system and into our economy.

b. **Rhode Island Department of Health Statewide Health Inventory Utilization and Capacity 2015**

In 2015, The Rhode Island Department of Health published a Statewide Health Inventory – Utilization and Capacity Study as required by the Rhode Island Access to Medical Technology Innovation Act [RIGL Chapter 23-93]. This study consisted of a series of surveys of health and the state's resources as well as a "Patient and Community survey to understand access to care from the perspective of community members." Pg.4. While this study does not address Trauma Care in particular, the proposed project is clearly consistent with certain findings.

i. **The continued need to address falling hospital occupancies: The Inventory clearly echoes and supports the findings of the earlier Report to General Assembly discussed above. Its finding (Pg.46) demonstrates that the concerns expressed in the 2013 Report have not softened since its preparation. The Inventory points out that inpatient admissions have continued to drop in subsequent years from approximately 128,000 in 2012 to 122,000 in 2014. The importance of the contribution of the proposed project to alleviation of the occupancy problem is well highlighted by the stubborn continuation of this problem.**

ii. **The survey also reveals continued increase in the use of emergency rooms in Rhode Island. This is accompanied by findings of a certain degree of overcrowding and queuing in the state's EU's:**

> "One quarter of the respondents (26.3%) strongly agreed or agreed that "where they get medical care, people have to wait too long for emergency treatment." A similar percentage (26.6%) was uncertain and 47.1% disagreed or strongly disagreed with this statement. Pg. 112

The proposed project will contribute to the alleviation of this weakness by creating more emergency room capacity in the northern Rhode Island area. While this improvement is designed particularly to accommodate trauma patients, it will benefit others as well by reducing waiting ques and generally improving workflow throughout the system.

7.) Please discuss the proposal and present the demonstration of the public need for this proposal. Description of the public need must include at least the following elements:

A. **Please identify the documented availability and accessibility problems, if any, of all existing facilities, equipment and services available in the state similar to the one proposed herein:**

Facility / Service Provider	Type of Service	Availability Problems (Y/N)	Documented Accessibility Problems (Y/N)	Distance fr. Applicant (Miles)
Rhode Island Hospital – Providence, RI	Level 1 DTC, ACOS Verified	N	N	15 mi
Beth Israel Medical Center – Boston, Ma	Level 1 DTC, ACOS Verified	N	N	48.3 mi
Boston Medical Center -Boston, Ma	Level 1 DTC, ACOS Verified	N	N	51.2 mi

Massachusetts General Hospital – Boston, MA	Level 1 DTC ACOS Verified	N	N	49.9 mi
Brigham & Womens' Hospital - Boston, Ma	Level 1 DTC, ACOS Verified	N	N	48.3 mi
South Shore Medical Center -Weymouth Ma	Level 2 DTC ACOS Verified	N	N	46.8 mi
UMass Memorial Medical Center – Worcester. Ma	Level 1 DTC, ACOS Verified	N	N	29.1 mi

B. Please discuss the extent to which the proposed service or equipment, if implemented, will not result in any unnecessary duplication of similar existing services or equipment, including those identified in (A) above.

> **"Most Americans assume that if they're in a car wreck or another severe injury befalls them, an ambulance will arrive quickly and whisk them away to a hospital that can handle their particular condition. But in many places that assumption would be wrong."**
>
> **Nearly 45 million Americans do not have access to a Level I or Level II trauma center within the "golden hour" after they are injured, according to 2009 Centers for Disease Control and Prevention data. Although most injuries can be handled at a local emergency department, treatment of severe injuries at a Level I trauma center lowers the patient's risk of death by 25 percent."**
>
> **"To close the gaps, many states either have developed statewide trauma systems over the past decade or are in the process of creating them. However, "the overall landscape across the United States is islands of excellence surrounded by large portions of our country where injured patients don't have access to a trauma system," says A. Brent Eastman, M.D., chief medical officer of Scripps Health in San Diego and chair of trauma at Scripps Memorial Hospital La Jolla."[7]**

National data on the annual treatment of medical trauma in the U.S. indicates that almost half of all patients fail to receive the benefit of treatment at an appropriate ACOS Certified facility. In 2013, for example, over 46% of patients diagnosed with trauma were not treated at DTC facilities - an amount that clearly documents availability and accessibility problems throughout the country.[8]

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[7] *Closing the gaps in the nation's trauma system; Hospitals & Health Networks, Oct.,2012*

[8] *DHHS Healthcare Utilization and Cost Project (HCUP) query system hcupnet.gov, Nov, 2016*

Access to trauma centers is frequently inhibited by a number of barriers:

Availability: The distribution of Trauma Centers is uneven across the U.S.:

> "Although the overall number of trauma centers has increased over the last decade, recent studies have shown that their geographic distribution varies widely across states. These studies suggest that in many areas of the country residents are without timely access to trauma centers that could save their lives. In other areas, there may be too many trauma centers, possibly leading to inefficiencies, lower patient volumes per center, and reduced quality of care."[9]

Supply of Services: There are an estimated 746[10] ACOS certified Trauma Centers (Levels I-III) in the U.S. resulting in a ratio of almost 2.5 centers per million population. Inefficiencies in the distribution of these facilities inhibit access to them for substantial portions of the population. In Rhode Island, there is one Trauma Center located at Rhode Island Hospital available to the state's one million residents. The residents of greater Boston (4.9 million) with five such Centers have a similar ratio of centers to population. The remainder of Massachusetts has three Level 1 Trauma Centers to serve approximately two million persons. While western MA has the best ratio of Centers to population, it encompasses a much larger geographic area and requires much greater travel times for large portions of its population. The Applicant's proposed service area, which lies in Northern Rhode Island and Southeastern Massachusetts, lacks any Trauma Center within its boundaries. Area residents must rely on the Boston, Worcester and Providence centers for trauma care.

Accessibility: As noted above, Trauma treatment is time sensitive. The sooner a patient can be assessed at a qualified treatment center, the greater the chances of survival and optimal outcome. Trauma Center access is a matter of time as opposed to distance. While an incident may occur at a site that is not very far from trauma care in miles, a variety of circumstances may nevertheless impede access. These circumstances are familiar: road networks, traffic conditions, rescue response times and even weather conditions can leave trauma treatment beyond reach. As reflected in the national statistics citied above, many patients must therefore seek care at Emergency Units that are not especially well equipped to address medical trauma. The result, as reflected above, is loss of life and inadequate care.

Improvement to Be Gained: The Applicant's proposal will remediate this situation for residents of the proposed service area. This statement is based upon the following observations:

Northern Rhode Island and southeastern Massachusetts comprise a contiguous region bounded to the south by Providence and to the north by the portion of

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[9] *Branas, MacKenzie & Williams, et al; Access to Trauma Centers in the U.S., JAMA. 2005;293(21):2626*

[10] *Committee on Trauma, American College of Surgeons. NTDB Annual Report 2015.Chicago, IL.*

Interstate 90 running east-west between Worcester, Ma and Boston. The major road systems in this area form an inverted triangle or a "V" with Providence at its tip to the south. (See Figure 1).

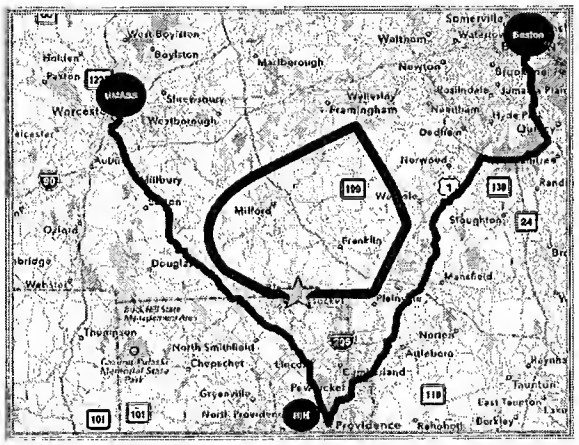

Figure 1: The Road System Serving Proposed Service

Area trauma victims must currently be transported south to RIH or north to either Worcester (northwest) or Boston (northeast) – depending upon the precise location of the incident.

The area's primary north-south routes include U.S. interstate 95 (Providence to Boston) and RI Rt. 146 – a limited access highway running northwest between Providence and Worcester. These arteries define a major circulation pattern in the shape of a "V" with its base to the south at Providence and its two arms reaching north. (See Figure 1.)

These travel routes work well for incidents occurring in the immediate vicinities of Worcester, Boston or Providence or in towns with excellent access to one of the two major north-south travel routes. Travel becomes more problematic for trauma occurring roughly in the area enclosed by green in Figure 1. This is true for several reasons:

Travel distance for many communities (in the green area) increases markedly as the north-south routes (i.e., arms of the "V") extend north and spread further and further apart.

As this occurs, the geography in between these arms becomes more exurban in character and is served by a secondary road system designed primarily to support travel within the area rather than conduct traffic through it.

Depending on the location of an incident within this "green zone", ambulances must travel indirect routes on secondary roads simply to reach the main highways leading north to Boston or Worcester or south to Providence. While distance to treatment may not differ much geographically among towns (as the crow flies), actual travel times can vary wildly.

Additionally, travel from this area to Worcester, Providence or Boston bears substantial risk of delay depending on time of day. This is an important, potentially life threatening, risk for trauma patients transported to any of the existing DTC's.

Conversely, travel times to Landmark from this area are generally shorter, more direct and less risky than those to alternative providers. This makes a Trauma Center located at LMC an obvious choice for many cases arising in this area – especially for those in the area marked by the green circle on Figure 1.

These factors suggest that a trauma center located at LMC would provide a significant "travel time advantage" for many trauma victims residing in the target service area for the proposed project.

Evidence of Unmet Need: As identified above, nationwide data on trauma treatment demonstrate that large percentages of trauma victims do not obtain the benefit of specialized treatment. As has already been pointed out, in 2013, 45% of patients diagnosed with trauma fell into this category. While this information applies to the nation as a whole, evidence indicates trauma supply in our area of the country is, in general, not better and possibly even worse than elsewhere.

i. **High Utilization, Low Supply: In comparing the trauma incidence with supply across the various regions of the country, the northeast in general demonstrates the greatest difficulties. That is, that northeast has both the highest rate of trauma nationally as well as the fewest DTC's per 1M population:**

Table 1 demonstrates that residents of the Northeast incur trauma at a rate almost 17% higher than the nation as a whole, while its supply of trauma centers per 1M population is almost 36% below the national average. This combination of circumstances suggests that availability of Trauma care is particularly constrained in this region of the country and the ability of victims to obtain specialized trauma care is generally no better than the nation as a whole and may actually be worse.

Table 1 Trauma Center Supply per 1M U.S. Pop by Region

(1)	(2)	(3)	(4)	(5)	(6)
Region	Cases w/ DX Trauma	Pop 2013 / 1,000	Trauma / 1000 Pop	DTC's	DTC's / 1M Pop
Northeast	5,057,151	55,943	90	118	2.11
Midwest	5,638,468	67,548	83	218	3.89
South	9,168,322	118,383	77	248	4.43
West	4,295,754	74,254	58	159	2.84
National Avg.			77		3.32

Sources: HCUPNET, U.S. Census, National Trauma Database

Definitions:

(1) Region of the US as designated in the HCUP database
(2) Number of Cases Identified in HCUP database presenting at hospital EU's in 2013 with a First-Listed diagnosis of Trauma
(3) HCUP Region Population 2013 identified by HCUP and divided by 1,000
(4) Column (2) divided by Column (3)= Rate of Trauma by Region per 1000 population
(5) Count of Trauma Centers per Region identified by National Trauma Database
(6) Column (5) divided by (Column (2)/1,000,000. Shows the ratio of DTC's per 1Million population for each region.

ii. <u>High Mortality</u>: **High mortality rates in the Northeast from certain types of frequently occurring trauma is another indicator of the need for greater access to trauma care in our area. In 2014, for example, the CDC reported that death from accidents in Rhode Island exceeds the national average by 30% as did deaths from all trauma (5%) while**

deaths from drug and alcohol related accidents were 30% and 50% greater respectively.[11] While there may be many reasons for increased mortality from these causes, greater access to trauma treatment would reduce these rates.

While there are no trauma centers located within the service area for the proposed project, area residents by necessity rely upon centers located in Boston, Worcester and Providence. As noted above, travel times to these locations can inhibit access for these residents due to traffic conditions, road networks and simple distance. The proposed program will provide a more readily available alternative that is generally free from traffic delays for many area residents. Moreover, it will facilitate access to Level I & II Centers for those patients requiring such services. That is, by coming first to LMC, such patients will achieve more rapid stabilization and immediate transport to the higher level facility as necessary.

C. Please identify the cities and towns that comprise the primary and secondary service area of the facility. Identify the size of the population to be served by this proposal and (if applicable) the projected changes in the size of this population.

The Service Area for the proposed program and associated population is listed by town in Table 2. It consists of the Applicant's current Primary Service area (marked with *) plus the addition of certain MA cities and towns located to the north of LMC (see green circled area in Figure 1 above). Towns included from this area were judged to lie in closer travel time proximity to LMC than to other alternative providers in Boston, Worcester or Providence.

As Table 2 demonstrates, the size of the population to be served by this proposal is approximately 316,000 residents increasing to 330,000 by 2020.

[11] *Centers for Disease Control, National Vital Statistics Report Vol 65 No 4; 6/16*

Table 2: Project Service Area			
		2013	2020 Proj.
Rhode Island Towns			
RI*	Woonsocket	41,113	38,591
RI*	Burrillville	16,015	15,713
RI*	Cumberland	33,705	34,698
RI*	Glocester	9,801	9,816
RI*	Lincoln	21,177	21,857
RI*	N. Smithfield	12,019	12,200
RI	RI Total	133,830	132,875
Massachusetts Towns			
MA*	Bellingham	16,438	18652
MA*	Blackstone	9,035	9901
MA*	Millville	3,197	4164
MA	Foxborough	16,990	18,059
MA	Franklin	32,064	33,490
MA	Holliston	13,811	13,283
MA	Hopedale	5,928	6,168
MA	Hopkinton	15,271	15,870
MA	Medway	12,866	13,146
MA	Mendon	5,851	6,527
MA	Millis	7,950	7,924
MA	Norfolk	11,409	12,398
MA	Upton	7,574	9,792
MA	Uxbridge	13,487	16,034
MA	Wrentham	11,058	11,378
MA	Total	182,929	196,781
	Total	316,759	329,661

D. Please identify the health needs of the population in (C) relative to this proposal.

The National Trauma Database lists over 20 common types of trauma that routinely occur throughout the population. The most frequent of these are falls, followed by motor vehicle accidents, falling objects, sharp objects and gunshot wounds. Males account for a slightly higher percentage of trauma incidents (52%) and victims occur in virtually every age group:

Table 3: Trauma by Age, 2013	
<1	0.82%
1-17	26.37%
18-44	40.02%
45-64	19.89%
65-84	9.67%
85+	3.22%

As indicated, the targeted service area for the proposed project includes over 300,000 residents. Significant levels of trauma can be expected to be experienced by virtually all segments of this population on an annual basis.

With the exception of a small percentage of these persons (roughly 10%), virtually all live in areas that are rated below average for health status factors and health outcome.[12] Lower health status emphasizes the importance of effective trauma care. That is, patients with health deficits are generally at greater risk of complications, permanent disability or death when suffering serious trauma. At the same time, low outcome rankings for these populations indicates the need for improvement in care systems.

As is the case with most populations in the U.S., the population in the proposed service area requires substantial trauma care on an annual basis. The Applicant has quantified these needs in planning for the proposed project.

1) The Needs of Trauma Patients

As noted above, trauma is not a disease, per se. It does not arise from a natural disease process and cannot be addressed using standard disease treatment protocols. Trauma arises from a unique external event, i.e., an accident. Great variation exists

[12] *Countyhealthrankings.org*

in the extent and nature of each patient's particular injuries. This is demonstrated by the fact that there are over 150 distinct diagnostic codes for trauma. Each code, in turn, has its own set of variations and sub-classifications.

For these reasons, optimum outcome requires the services of a facility with special resources and expertise dedicated to the treatment of trauma. As discussed above, such facilities are known as ACOS certified Trauma Centers or Designated Trauma Centers (DTC's). DTC Levels I-III are particularly well prepared to rapidly treat trauma. The literature demonstrates that reaching such a facility in an appropriate time window can often be a matter of life or death.[13] While great progress has been made over many years, nationwide statistics show that such rapid access to Trauma centers continues to be problematic in much of the country. The simple fact, as noted above, is that barely more than half of all trauma patients ever obtain the benefit of this care.[14]

The need for rapid access is important even for patients with injuries that ultimately are determined to be less severe than they first appear. That is, given the broad nature and wide variation of possible injuries, a patient's condition can often not be accurately assessed until he or she obtains evaluation at a DTC. The converse is also true: patients who appear gravely injured may require less intervention than expected after careful evaluation.

In summary, an imminent threat to life, whether certain or reasonably likely, requires immediate medical attention and warrants rapid access to trauma care. While some health plans require a hard and fast timeframe of no more than sixty minutes travel time to a trauma facility, the more common consensus guideline is "the quicker the better."[15]

Two Groups of Patients

Given the above, it can be said that Trauma Centers meet important needs for patients who are 1) clearly suffering from severe trauma injuries as well as those 2) suspected of suffering severe trauma but who require further assessment and evaluation before risk to life can be accurately assessed. For the purpose of the following discussion, the first group of patients described above is referred to as "Type 1" trauma patients and the second group is labeled "Type 2".

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[13] *Mackenzie et al., A National Evaluation of the Effect of Trauma Center Care Mortality, New England Journal of Medicine, 2006, Mackenzie et al., Trauma Centers Clearly Lower Risks of Death, Johns Hopkins Commentary, January 26, 2006.*

[14] *Closing the Gaps in the Nation's Trauma System - Hospitals and Health Networks Magazine, October 2012*

[15] *Tien HC, Jung V., et al: Annals of Surgery, Reducing Time-To-Treatment decreases mortality of trauma patients with acute subdural hematoma. SB 2011 June: 253(6): 1178-83 better."*

Type 1 patients require Trauma Care for obvious reasons, i.e., they are suffering from life threatening injuries and clearly require immediate specialized and highly intensive services. Type 1 patients are typically assessed in the field by EMTs or other first responders and transported as quickly as possible to a Trauma Center EU (if available) then stabilized and admitted for inpatient care. As indicated above, Type I patients - like trauma victims generally - frequently lack adequate access to a Trauma Center and must often resort to a general hospital EU for emergency care instead.

Type II patients are often those who have not had a field assessment or who have had a field assessment that is inconclusive with respect to the severity of their injuries. In such cases, rescue units err on the side of caution and transport patients to a trauma center (if possible) to obtain clarification of their condition and treatment as necessary.

Other Type II patients are transported to treatment by private auto, by police or other means. Such patients have typically not received a comprehensive field assessment before they arrive. They come to the trauma center because they believe their condition is serious and understand a trauma-capable facility to be their best option for treatment. Many if not most patients arriving in this manner are eventually treated in the emergency unit and discharged because their trauma assessment has determined that they do not require inpatient care.

Type I and Type II patients illustrate two critical functions performed by Trauma Centers. The first is to simply determine as quickly as possible the patient's condition and need for services. The second is to rapidly determine the need for intensive care and initiate such care when necessary. Both of these levels of services are essential and time sensitive for injured patients even when it is determined that immediate aggressive treatment is not required.

In preparing this application, the Applicant has considered the needs of the area population for both Type I and Type II trauma services.

Projected Volume of Trauma in the Target Area

The fact that large percentages of trauma patients fail to receive the benefits of trauma care in many areas of the country[16] is obvious from nationwide statistics that show almost half of all persons diagnosed with trauma fail to reach a trauma center for treatment. The goal of this project is to improve these percentages for residents of the Applicant's targeted service area.

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[16] *Closing the Gaps in the Nation's Trauma System - Hospitals and Health Networks Magazine, October 2012*

In quantifying the patient need for the proposed program, the Applicant estimated future trauma volumes within the area -- including the number of victims expected to obtain trauma care and the number projected to be unable to do so. The Applicant believes that the latter group constitutes a substantial unmet need and an extensive group of area residents who will benefit from this program.

In developing these volume estimates, the Applicant considered both Type I and Type II patients as described above. In the first instance a single patient in need represents both an emergency room visit and inpatient hospitalization. In the second case, each patient represents a trauma emergency room visit only.

The process the Applicant used in developing these estimates is described as follows: Detailed historical utilization data for trauma care were obtained from the DHHS Hospital Utilization and Cost Project (HCUP). These data were collected and analyzed through the HCUP online portal. This analysis included statistics on all patients in the country that are diagnosed with trauma in a given year. Information on several key variables was collected including the number of trauma-related EU visits and inpatient admissions. Data were collected for both patients treated at ACOS Certified Trauma Centers as well as those -with clear diagnoses of trauma- who were nevertheless treated at routine general hospitals. Using these data, the Applicant established annual utilization rates as follows:

a. **The annual rate at which patients require trauma care per year;**

b. **The annual rate at which patients are able to obtain their care at an ACOS Certified Trauma Center;**

c. **The rate of patients requiring Type I trauma care consisting of an EU Visit immediately followed by an Inpatient Admission; and**

d. **The rate of patients requiring Type II trauma care consisting of an EU Visit only.**

The Applicant subsequently obtained HCUP data on the percentage of variation in use of trauma care in various regions of the country including the northeast region. The rates described above were then adjusted to reflect the level of utilization for the northeast.

After establishing adjusted utilization rates as described above, the Applicant obtained population data from the U.S. Census Bureau for the towns comprising its proposed service area (See Table 2, above). These included population counts for

2013 and projected counts for 2018 and 2020. Applying the utilization rates described above to the population counts for 2018, the Applicant estimated the trauma volumes in the targeted service areas follows:

Table 4: 2018 Projections of Trauma Volumes in Target Service Area

Type	Description	Total	Not TC	Not TC%	TC	TC%
2018 Type I	EU & Inpatient*	2,007	728	36%	1,279	64%
2018 Type II	EU Only	25,579	11,982	47%	13,597	53%
Total	Type I & II	27,586	12,710	46%	14,876	54%

TC = Patient received Trauma Center Care
Not TC = Patient did not receive Trauma Center Care
** These totals are adjusted for double counting between Type I and II patients.*

As these projections demonstrate, the population in the targeted service area incurs over 27,000 incidents of trauma per year that require an acute level of service. Of this total, an average of 46% of patients fail to obtain care at a Certified ACOS Trauma Center. This results in an unmet need for Trauma Care of 12,710 patients. Of these, 728 are estimated to be Type I and require inpatient care. The remaining 11,982 patients require EU services only.

Computation of Trauma Volumes and Projected Need

1. The Applicant obtained the population census for 2013, the most recent year for which comprehensive trauma injury data are available for the US.
2. Source: Health Cost and Utilization Project 2013.
3. The Applicant obtained census data for 2013 as a means of establishing a sound basis for utilization rates of trauma services. This was done for the U.S. as well as the local service area on a town level.
4. Source: U.S. Bureau of the Census.
5. Population levels were obtained through 2020 based U.S. census data estimates.
6. The Applicant obtained use rates for the following victims of trauma:

    a. Trauma Patients served at Trauma Centers:

        i. Persons with a trauma diagnosis* who were admitted to a DTC EU and to the same hospital for inpatient care.
        ii. Persons with a trauma diagnosis* transferred to a DTC for Inpatient Care after admission to a non-DTC EU.
        iii. Persons with a trauma diagnosis* admitted to a non-DTC EU and to the same hospital for inpatient care.

iv. **Persons with a trauma diagnosis* admitted to a non-DTC EU and discharged.**

*** Persons with a trauma diagnosis are defined as all patients with a primary diagnosis of trauma. Persons with a secondary diagnosis of trauma were excluded from the analysis resulting in a reduction of the "trauma pool" by more than 50%.**

7. **Trauma utilization rates were computed by dividing the number of trauma patients by the U.S. population and determining a utilization rate for the U.S.**
8. **Using the same HCUP database, the Applicant identified the utilization rate for different regions in the U.S. because these are historically known to vary from region to region.**
9. **The Trauma Utilization Rate was then increased by 11% to reflect the greater frequency of Trauma Care in the Northeast. (The NE Trauma rate)**
10. **Four separate NE Trauma Rates were determined for each of the four classifications of trauma patients described above. (See i-iv above)**
11. **Each of the four separate Trauma Rates was applied to the service area population to determine the projected volume of trauma care in 2018 and the numbers of persons falling into Type I and Type II classification.**

    i. **Type I classification was determined by:**

       a. **Estimating the number of persons meeting criterion (i) above by multiplying the use rate established for that group, and**
       b. **Estimating the number of persons meeting criterion (ii) above by multiplying the use rate established for that group, and**
       c. **Combining the two estimates just described.**

    ii. **Type II classification was determined by:**

       a. **Estimating the number of persons meeting criterion (iii) above by multiplying the use rate established for that group, and**
       b. **Estimating the number of persons meeting criterion (iv) above by multiplying the use rate established for that group, and**
       c. **Combining the two estimates just described.**

12. **In determining the total number of trauma patients, the Applicant avoided double counting by subtracting one time the total number of inpatients from the grand area total because each inpatient is, by definition, counted in the data twice, i.e., as both an inpatient and an outpatient.**

E. Please identify utilization data for the past three years (if existing service) and as projected through the next three years, after implementation, for each separate area of service affected by this proposal. Please identify the units of service used.

Emergency Department

Actual (last 3 years)	FY 2014	FY 2015	FY 2106
Hours of Operation	24 h / day	24 h / day	24 h / day
Utilization (#)	38,749	38,906	38,240 *
Throughput Possible (#)	30,000	30,000	30,000
Utilization Rate (%)	129%	130%	127%

***YTD November 2016 annualized**

Emergency Department

Projected	FY 2019	FY 2020	FY 2021
Hours of Operation	24h / day	24 h / day	24 h / day
Utilization	44,231	46,442	48,764
Throughput Possible	50,000	50,000	50,000
Utilization Rate (%)	89%	93%	98%

Inpatient Census (Licensed Beds)

Actual (last 3 years)	FY 2014	FY 2015	FY 2106*
Hours of Operation	24 h / day	24 h / day	24 h / day
Utilization (#) (ADC)	85.2	84.2	68
Throughput Possible (#)	214	214	214
Utilization Rate (%)	39.8%	39.3%	31.7%

***Through 11/2016, annualized**

Inpatient Census (Licensed Beds)

Projected	FY 2019	FY 2020	FY 2121
Hours of Operation	24 h / day	24 h / day	24 h / day
Utilization (#)(ADC)	75	79	83
Throughput Possible (#)	214	214	214
Utilization Rate (%)	36.9%	38.3%	40.2%

F. Please identify what portion of the need for the services proposed in this project is not currently being satisfied, and what portion of that unmet need would be satisfied by approval and implementation of this proposal.

As demonstrated in response to Question 7-D above, the Applicant projects that 728 inpatients and 11,982 outpatients requiring trauma center care will not obtain it in 2018. These persons represent 36% of those in need of inpatient care and 47% needing outpatient care in the area. Applying a basic project market share percentage of 50% (and accounting for both transfers from other Non-DTC hospitals to LMC as well as transfers from LMC to DTC's offering higher level care), the Applicant projects the following levels of service for this program:

Table 5: Trauma Center Volumes		
Projected 2019		
	Total Need	Volume Projected
EU Visits	11,982	5,991
Inpatients	728	510
** Inpatient projection assumes 50% of Total Need Plus Net Gain of 146 patients from inter-hospital transfers.*		

As the Table above indicates, the Applicant projects that this project will meet approximately 50% of the unmet demand for outpatient trauma care and 70% of the care for those requiring hospital admission.

G. Please identify and evaluate alternative proposals to satisfy the unmet need identified in (F) above, including developing a collaborative approach with existing providers of similar services.

The Applicant considered the alternatives of establishing a Level 1 or Level II Trauma Center. These alternatives were rejected in favor of the proposed project for the following reasons.

The Applicant believes that the fundamental problem with access to trauma care in the targeted service area is the lack and maldistribution of Trauma Centers. The Applicant believes that there is no alternative for responding to the unmet need as described above without creating an additional center that is more easily accessible by area residents. The Applicant had considered the alternatives of developing a Level I or a Level II trauma enter as opposed to the Level III facility proposed in this application. These alternatives were rejected for the following reasons:

a. **Expense: The development of a Level 1 or II Trauma Center would have added considerable development and operating costs to the proposal requiring, for example, considerable expansion of surgical and intensive**

care capacities of the hospital. Management believes that such additional expenditures would not be a prudent use of its resources.

b. **Need: The additional cost of developing a Level 1 or II facility is unnecessary given the Level III capabilities of the proposed program. This is true in part because a key function of the proposed program would be to facilitate the rapid and safe transfer of patients requiring the services of centers with broader capabilities. That is, for many such patients, rapid assessment and stabilization followed by immediate transfer will be preferable to direct but longer transportation to a Level I or II facility.**

This process, moreover, will be facilitated through transfer agreements with Level I and II facilities located outside the service area. Transfer agreements will incorporate transfer protocols and pre-transfer consultation on patients requiring transfer. Such agreements are required elements of the ACOS program. Thus far, LMC has entered into one such agreement with Rhode Island Hospital. See Exhibit 1. This form of agreement will be used by LMC as a basis for other agreements with other community providers.

With regard to collaboration, the Applicant notes that considerable collaboration has been contemplated and will be undertaken with various organizations and groups. Certification in fact requires several distinct forms of collaboration such as transfer agreements and protocols with other trauma centers and general community hospitals as well. Trauma Centers must participate in the training of prehospital personnel in the community and in the development and improvement of prehospital care protocols. See Exhibit 1 for a draft prehospital training policy that will be reviewed by the Trauma Team. Senior staff must also seek out and participate in regional and statewide trauma system meetings and committees that provide input and guidance into public health policy in their areas. LMC is and will continue to advance all forms of collaboration that improve the services it provides as well as the level of trauma care throughout the area.

H. Please provide a justification for the instant proposal and the scope thereof as opposed to the alternative proposals identified in (G) above.

The proposed project addresses a substantial unmet need for Trauma Care within its service area. It is the least costly alternative, as described above, for improving the percentage of trauma victims who are able to obtain the specialized expertise and resources of a Designated Trauma Center. In making this possible for more than 50% of those who presently cannot obtain this care, the project will make a significant contribution to the health status of area residents, further the goal of strengthening the Rhode Island acute care system and bring needed resources into the state.

HEALTH DISPARITIES AND CHARITY CARE

8.) The RI Department of Health defines health disparities as inequalities in health status, disease incidence, disease prevalence, morbidity, or mortality rates between populations as impacted by

access to services, quality of services, and environmental triggers. Disparately affected populations may be described by race & ethnicity, age, disability status, level of education, gender, geographic location, income, or sexual orientation.

A. Please describe all health disparities in the applicant's service area. Provide all appropriate documentation to substantiate your response including any assessments and data that describe the health disparities.

In its 2015 Legislative Report, The Rhode Island Commission on Health Advocacy and Equity defines health disparities as follows:

> **"Health disparities are differences in health between population groups. Disparities include inequalities in the rates and severity of diseases and other adverse health conditions, as well as mortality. Because disparities are simply differences, sometimes they are preventable and sometimes they are not. For example, older people may face health disparities, such as higher rates of cancer, compared to younger people, but these types of disparities are to be expected due to aging. On the other hand, disparities based on factors such as educational level, disability status, income, or housing conditions can be addressed. A health disparity related to a social, economic, and/or environmental disadvantage is called a health inequity. Health disparities are particularly problematic for those who identify with characteristics linked to discrimination or exclusion."**

As noted from the quotation above, the Commission draws an important distinction between "Health Disparities" and "Health Inequities", i.e. disparities are related to social and economic factors which are possible for a community to eliminate or improve. These are typically associated with special populations or socioeconomic groups.

The full range of diverse population exists in significant numbers throughout the service area for the proposed project including both the Rhode Island and Massachusetts portions. While the levels of inequalities differ in each state, they are nevertheless pervasive through the target population.

<u>Presence of Special Populations</u>: As the following data demonstrate, a diversity of special populations exist throughout the Massachusetts and Rhode Island portions of the project's service area. While concentrations tend to be greater within Rhode Island, special populations are clearly present across the entire population.

Table 6. Special Populations within the Target Service Area by County

County:	US	RI	Prov	MA	Brist	Worc	Norf
Black or African American	13.3%	7.9%	11.7%	8.4%	4.9%	5.5%	7.1%
American Indian	1.2%	1.0%	1.2%	0.5%	0.6%	0.4%	0.2%
Asian	5.6%	3.6%	4.5%	6.6%	2.3%	4.9%	10.6%
Hawaiian, Pacific Islander	0.2%	0.2%	0.3%	0.1%	0.1%	0.1%	0.1%

Two or More Race	2.6%	2.6%	3.1%	2.3%	2.1%	2.1%	1.9%
Hispanic or Latino	17.6%	14.4%	21.3%	11.2%	7.2%	10.8%	4.2%
High school graduate or higher	86.7%	86.2%	82.1%	89.8%	82.8%	89.8%	93.9%
Bachelor's degree or higher	29.8%	31.9%	26.8%	40.5%	25.9%	34.4%	50.6%
Disability, <age 65 years	8.6%	8.9%	9.2%	7.9%	10.1%	8.4%	6.1%
No health insurance, under age 65 years	10.5%	6.7%	10.4%	3.3%	4.3%	3.5%	2.7%
Median household income (000)	$54	$57	$50	$69	$57	$65	$88
Per capita income (000)	$29	$31	$27	$37	$30	$32	$46
Persons in poverty	13.5%	13.9%	17.2%	11.5%	12.6%	12.1%	7.1%

Inequalities in both access to basic health care as well as variations in outcomes exist across these populations and throughout the entire area. This is demonstrated through a variety of data.

Health Access

Data available through the Department of Health's website (health.ri.gov) demonstrate several key inequalities among special populations, notably the following:

- **Persons who are uninsured experience disparities between / among various population groups. Examples include disparities by:**
    a. **Gender: Males (18%) and females (11%)**
    b. **Age Groups: 28-34 (23%) and 35-49 (15%)**
    c. **Racial & Ethnic Groups: Hispanic (22%) and Black (38%)**
- **Disparities exist with respect to the likelihood that individuals will have a personal doctor or health care provider:**
    a. **Gender: Males (19%) and females (9%)**
    b. **Age Group: 28-34 (28%) and 35-49 (11%)**
    c. **Race & Ethnic Groups: Hispanic (22%) & Black (11%)**
- **Persons who have had had no routine checkup in past 12 months:**
    a. **Gender: Males (28%) and females (9%)**
    b. **Age Group: 28-34 (33%) and 35-49 (25%)**
    c. **Race & Ethnic Groups: Hispanic (21%) & Black (37%)**
- **Persons who can't afford health care**
    a. **Gender: Males (15%) and females (13%)**
    b. **Age Group: 28-34 (19%) and 35-49 (16%)**

c. **Race & Ethnic Groups: Hispanic (31%) & Black (18%)**

Additional evidence of disparities and inequalities are demonstrated by Kaiser Health Facts web data on Minority Health Comparisons by State for 2015 (www.kff.org).

Key examples are summarized as follows:

- **Diabetes: In Massachusetts, mortality rates from diabetes are more than twice as high for blacks (29.3) per /100 pop. as whites (13.5 /100k pop) .[17] While Kaiser does not provide similar data for Rhode Island, data on inequalities associated with diabetes are available in The Rhode Island Health Department 2010 Report, The Burden of Diabetes. This report identifies several inequalities in diabetes health including a higher prevalence of diagnosed diabetes among Black non-Hispanic adults (15.7%) and Hispanic adults (11.3%) compared to White non-Hispanic adults (6.7%). This report identifies other examples of inequalities as well noting:**

  "14.5% of adults who report annual incomes of less than $25,000 have diagnosed diabetes, compared to 10.7% of those who make between $25,000 and $75,000 annually and 7.9% of those who make $75,000 or more annually. In Rhode Island, adults who have less education also have a higher prevalence of diagnosed diabetes (12.0% among adults with less than high school education, 7.5% among adults with a high school or equivalent education, and 6.4% among adults with at least some college education)." [18]

Evidence of yet further disparities can also be found in statistics compiled each year by the U.S. Centers for Disease Control.[19]

- **Overall Annual Mortality Rate differ between blacks and whites throughout the service area:**

Tab 6.1 Mortality Rates		
Race:	**White**	**Black**
MA	**12%**	**20%**
RI	**13%**	**30%**

[17] *KHF*
[18] *RI Diabetes report*
[19] *CDC Health Disparities & Inequalities Report (CHDIR) https://www.cdc.gov/minorityhealth/chdireport.html*

- **Men lacking a relationship with a personal physician: While 16% and 18% of Rhode Islanders report no relationship, more extreme variation occurs by race:**

Table 6.2 Males w/o Personal Physician					
Race:	All	White	Black	Hisp	Other
MA	16%	12%	20%	30%	27%
RI	18%	13%	30	38%	NA

- **Racial inequalities also affect MD services for women in both the Rhode Island and Massachusetts portions of the service area:**

Table 6.3 Women w/o Routine MD Visit >1year					
Race:	All	White	Black	Hisp	Other
MA	16%	12%	20%	30%	27%
RI	18%	13%	30%	38%	NA

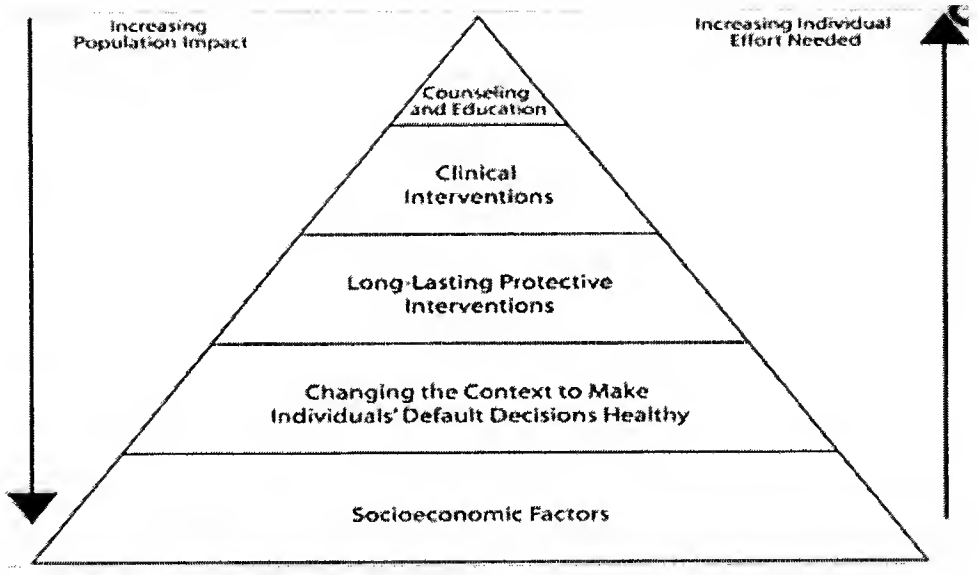
- **Reported health status among women also varies by race:**

Table 6.4 Women Reporting Poor Health Status					
Race:	All	White	Blck	Hisp	Oth
MA	14%	12%	18%	30%	N/A
RI	17%	14%	21%	33%	NA

There can be no question that disparities and inequalities pervade the health care system throughout the proposed service area and are suffered by a broad variety of racial and socioeconomic groups.

B. Discuss the impact of the proposal on reducing and/or eliminating health disparities in the applicant's service area.

The effect of the proposed project in eliminating health inequalities can be stated in terms of the "Health Impact Pyramid" cited by the RI Department of Health, Division of Health Equity. This is a dynamic model of change that includes 6 levels of intervention. The proposed project will exert an impact on at least two of these six levels including "Community Education" and "Clinical Interventions."



These impacts are further described as follows:

- **<u>Clinical Interventions / Access to Trauma Care</u>: As described throughout this application, the proposed project will make trauma care more accessible to those who cannot access it readily. Policies at LMC will ensure that these services are available to all patients regardless of their circumstances. These include the following:**

    a. **Accepting all patients without regard to ability to pay;**
    b. **Ensuring the ready availability of translation services; and**
    c. **Assisting all patients in establishing appropriate clinical relationships once they are discharged from the hospital or EU – both for follow-up of their trauma injuries and their ongoing primary care.**

- **<u>Community Education / Public Awareness of Trauma Prevention</u>: While trauma is not the result of a natural disease process, its frequency can be reduced through public education. That is, if the population can be encouraged to adopt safe practices in physical activities, a certain degree of trauma could be avoided. Examples of such practices include drivers' training, education on avoiding falls or safety training in the use of machines and heavy equipment. LMC provides various types of safety training in its primary prevention efforts. These will be augmented through the Trauma Center. In offering such services, LMC will make efforts to reach out to special populations. This will include multilingual presentations and safety materials, outreach to special groups and similar activities.**

9.) Please provide a copy of the applicant's charity care policies and procedures and charity care application form.

See <u>Exhibit 9</u>

FINANCIAL ANALYSIS

10.) A) Please itemize the capital costs of this proposal. Present all amounts in thousands (e.g., $112,527=$113). If the proposal is going to be implemented in phases, identify capital costs by each phase.

CAPITAL EXPENDITURES ('000)		
	Amount	Percent of Total
Survey/Studies	$40	0.35%
Fees/Permits	$80	0.71%
Architect	$520	4.61%
"Soft" Construction Costs	$640	5.67%
Site Preparation	$500	4.43%
Demolition	$50	0.44%
Renovation	$150	1.33%
New Construction	$6,825	60.47%
Contingency	$782	6.93%
"Hard" Construction Costs	$8,307	73.6%
Furnishings	$200	1.77%
Movable Equipment	$200	1.77%
Fixed Equipment	$1,400	12.4%
"Equipment" Costs	$1,800	15.95%
Capitalized Interest	$0	0%
Bond Costs/Insurance	$92	0.82%
Debt Services Reserve[1]	$0	0%
Accounting/Legal	$50	0.44%
Financing Fees	$0	0%
"Financing" Costs	$142	1.26%
Land	$0	0%
Other (cost escalation)	$397	3.52%
"Other" Costs	$397	3.52%
TOTAL CAPITAL COSTS	$11,287	100%

[1] **Should not exceed the first full year's annual debt payment.**

B.) Please provide a detailed description of how the contingency cost in (A) above was determined.

Five (5) percent contingency was factored in for each of Design and construction.

C.) Given the above projection of the total capital expenditure of the proposal, please provide an analysis of this proposed cost. This analysis must address the following considerations:

i. The financial plan for acquiring the necessary funds for all capital and operating expenses and income associated with the full implementation of this proposal, for the period of 6 months prior to, during and for three (3) years after this proposal is fully implemented, assuming approval.

Funds for the project will be acquired from Prime Healthcare Services, Inc.

ii. The relationship of the cost of this proposal to the total value of your facility's physical plant, equipment and health care services for capital and operating costs.

The proposed capital costs are 23% of our gross Property Plant and Equipment ($11,286,500 per question 15/$50,029,000). The proposed incremental operating expenses represent a 4.7% increase over existing expenses (per question 18, $5,763,000/$123,563,000).

iii. A forecast for inflation of the estimated total capital cost of the proposal for the time period between initial submission of the application and full implementation of the proposal, assuming approval, including an assessment of how such inflation would impact the implementation of this proposal.

The proposed capital costs include 3.6% for inflation. (see cost escalation amount in question 10).

11.) Please indicate the financing mix for the capital cost of this proposal. **NOTE:** the Health Services Council's policy requires a minimum 20% equity investment in CON projects (33% equity minimum for equipment-related proposals).

Source	Amount	Percent	Interest Rate	Terms (Yrs.)	List source(s) of funds (and amount if multiple sources)
Equity*	$11,286,500	100%			Prime Healthcare Services, Inc.
Debt**	$	%	%		
Lease**	$	%	%		
TOTAL	$11,286,500	100%			

* Equity means non-debt funds contributed towards the capital cost of an acquisition or project which are free and clear of any repayment obligation or liens against assets, and that result in a like reduction in the portion

of the capital cost that is required to be financed or mortgaged (R23-15-CON).
**** If debt and/or lease financing is indicated, please complete Appendix F.**

12.) Will a fundraising drive be conducted to help finance this approval? Yes____ No X

13.) Has a feasibility study been conducted of fundraising potential? Yes___ No X

- If the response to Question 13 is 'Yes', please provide a copy of the feasibility study.

14.) Will the applicant apply for state and/or federal capital funding? Yes___ No X

- If the response to Question 14 is 'Yes', please provide the source: _____, amount: _____, and the expected date of receipt of those monies: _____.

15.) Please calculate the yearly amount of depreciation and amortization to be expensed.

Depreciation/Amortization Schedule - Straight Line Method					
		Equipment			
	Improvements	**Fixed**	**Movable**	**Amortization**	**Total**
Total Cost	**$9,486,500**	**$1,400,000**	**$400,000**	**$**	**$ 11,286,500**
(-) Salvage Value	**$**	**$**	**$**	**$**	**$**
(=) Amount Expensed	**$**	**$**	**$**	**$**	**$**
(/) Average Life (Yrs.)	**25**	**7**	**7**		
(=) Annual Depreciation	**$379,460**	**$200,000**	**$57,143**	**$**	**$ 636,603**

***1* Must equal the total capital cost (Question 10 above) less the cost of land and less the cost of any assets to be acquired through lease financing**
***2* Must equal the incremental "depreciation/amortization" expense, column -5-, in Question 18 (below).**

16.) For the first full operating year of the proposal (identified in Question 18 below), please identify the total number of FTEs (full time equivalents) and the associated payroll expense (including fringe benefits) required to staff this proposal. Please follow all instructions and present the payroll in thousands (e.g., $42,575=$43).

	Existing		Additions/(Reductions)		New Totals	
Personnel	# of FTEs	Payroll W/Fringes	# of FTEs	Payroll W/Fringes	# of FTEs	Payroll W/Fringes
Medical Director		$		$		$
Physicians	4.0	$4,217	6.0	$2,694	10	$6,911
Administrator		$		$		$
RNs	223.3	$21,056	11.3	$1,089	234.6	$22,145
LPNs	2.0	$181		$	2.0	$181
Nursing Aides	28.0	$2,098	8.4	$414	36.4	$2,512
PTs	12.0	$1,458	1.0	$122	13.0	$1,580
OTs	6.5	$792	1.0	$122	7.5	$914
Speech Therapists	2.5	$321	0.5	$64	3.0	$385
Clerical	101.0	$7,417		$	101.0	$7,417
Housekeeping	60.0	$2,250	4.5	$158	64.5	$2,408
Other: (all other staff)	298.9	$25,476	2.0	$86	300.9	$25,562
TOTAL	738.2	$65,266	34.7	$ 4,749	772.9	$70,015

***1* Must equal the incremental "payroll w/fringes" expense in column -5-, Question 18 (below).**

INSTRUCTIONS:

"FTEs" Full time equivalents, are the equivalent of one employee working full time (i.e., 2,080 hours per year)
"Additions" are NEW hires;
"Reductions" are staffing economies achieved though attrition, layoffs, etc. It does NOT report the reallocation of personnel to other departments.

17.) Please describe the plan for the recruitment and training of personnel.

Prime Healthcare Services – Landmark, LLC will use a combination of posting positions on the company website as well as other recruitment websites (e.g., Indeed.com) and national search firms for all physicians needed for this project.

18.) Please complete the following pro-forma income statement for each unit of service. Present all dollar amounts in thousands (e.g., $112,527=$113). Be certain that the information is accurate and supported by other tables in this worksheet (i.e., "depreciation" from Question 15 above, "payroll" from Question 16 above). If this proposal involved more than two separate "units of service" (e.g., pt. days, CT scans, outpatient visits, etc.), insert additional units as required.

PRO-FORMA P & L STATEMENT FOR WHOLE FACILITY					
	Actual Previous Year 2016 (1)	Budgeted Current Year 2017 (2)	<-- FIRST FULL OPERATING YEAR 2019 -->		
			CON Denied (3)	CON Approved (4)	Incremental Difference *1* (5)
REVENUES:					
Net Patient Revenue	$117,840	$121,362	$121,362	$130,680	$9,318
Other:	$3,758	$4,322	$4,322	$4,322	$
Total Revenue	$121,598	$125,684	$125,684	$135.002	$9,318
EXPENSES:	$	$	$	$	$
Payroll w/Fringes	$63,955	$65,266	$65,266	$70,015	$4,749
Bad Debt	$	$	$	$	$
Supplies	$17,046	$16,740	$16,740	$16,885	$145
Office Expenses	$3,125	$3,370	$3,370	$3,370	$
Utilities	$1,727	$1,680	$1,680	$1,806	$126
Insurance	$1,063	$1,430	$1,430	$1,537	$107
Interest	$382	$245	$245	$245	$
Depreciation/Amortization	$4,130	$4,431	$4,431	$5,067	$636
Leasehold Expenses	$1,260	$1,237	$1,237	$1,237	$
Other: (____)	$28,655	$29,164	$29,164	$29,164	$
Total Expenses	$121,343	$123,563	$123,563	$129,326	$5,763
OPERATING PROFIT:	$255	$2,121	$2,121	$5,676	$3,555

For each service to be affected by this proposal, please identify each service and provide: the utilization, average net revenue per unit of services and the average expense per unit of service.

Service Type:	Emergency Dept				
Service (#s):	38,240	38,240	38,240	44,231	5,991
Net Revenue Per Unit *8*	$450	$464	$464	$464	$0
Expense Per Unit	$110	$112	$112	$111	$(1)
Service Type:	Inpatient				
Service (#s):	6,242	6,429	6,429	6,939	510
Net Revenue Per Unit *8*	$8,505	$8,760	$8,760	$8,961	$201
Expense Per Unit	$2,636	$2,683	$2,683	$2,603	$(80)

INSTRUCTIONS: Present all dollar amounts (except unit revenue and expense) in thousands.

***1* The Incremental Difference (column -5-) represents the actual revenue and expenses associated with this CON. It does not include any already incurred allocated or overhead expenses. It is column -4- less column –3-.**

***2* Net Patient Revenue (column -5-) equals the different units of service times their respective unit reimbursement.**

***3* Payroll with fringe benefits (column -5-) equals that identified in Question 16 above.**

***4* Bad Debt is the same as that identified in column -4-.**

***5* Interest Expense equals the first full year's interest paid on debt.**

***6* Depreciation equals a full year's depreciation (Question 15 above), not the half year booked in the year of purchase.**

***7* Total Expense (column -5-) equals the operating expense of this proposal and is defined as the sum of the different units of service.**

***8* Net Revenue per unit (of service) is the actual average net reimbursement received from providing each unit of service; it is NOT the charge for that service.**

19.) Please provide an analysis and description of the impact of the proposed new institutional health service or new health equipment, if approved, on the charges and anticipated reimbursements in any and all affected areas of the facility. Include in this analysis consideration of such impacts on individual units of service and on an aggregate basis by individual class of payer. Such description should include, at a minimum, the projected charge and reimbursement information requested above for the first full year after implementation, by payor source, and shall present alternate projections assuming (a) the proposal is not approved, and (b) the proposal is approved. If no additional (incremental) utilization is projected, please indicate this and complete this table reflecting the total utilization of the facility in the first full fiscal year.

Projected First Full Operating Year: FY 2019									
	Implemented			**Not Implemented**			**Difference**		
Payor Mix	**Projected Utilization**		**Total Revenue**	**Projected Utilization**		**Total Revenue**	**Projected Utilization**		**Total Revenue**
	#	%	$	#	%	$	#	%	$
Medicare	26,097	51	66,648	22,781	51	61,895	3,316	0	4,752
RI Medicaid	11,257	22	28,750	9,827	22	26,700	1,430	0	2,050
Non-RI Medicaid									
RIteCare									
Blue Cross	5,629	11	14,374	4,914	11	13,349	715	0	1,025
Commercial	2,047	4	5,227	1,787	4	4,854	260	0	373
HMO's	1,023	2	2,613	893	2	2,427	130	0	186
Self Pay	1,535	3	3,921	1,340	3	3,641	195	0	280
Charity Care			$0			$0			0
Other:	3,582	7	9,147	3,127	7	8,495	455	0	652
TOTAL	51,170	100	130,680	44,669	100	121,361	6,501	0	9,318

 # = Number of ED visits and Inpatient Discharges.

20.) Please provide the following:

A. Please provide audited financial statements for the most recent year available.

See Exhibit 20A for audited financials for Prime Healthcare Services, Inc. and unaudited financials for the Applicant.

B. Please discuss the impact of approval or denial of the proposal on the future viability of the (1) applicant and (2) providers of health services to a significant proportion of the population served or proposed to be served by the applicant.

Trauma Care for residents of the targeted service area is presently provided by seven facilities located in Boston (5), Worcester (1), and Providence (1). All of these facilities are located outside of the area and primarily provide services to other locations. Approval of the proposal would ensure more timely access / stabilization of trauma injury to a large population, who currently must rely on the aforementioned facilities. If targeted volumes are met, there will be a positive impact on the applicant and its viability. However, notwithstanding the significant identified need, denial of the application will preclude trauma from being directed to a more local designated trauma facility. The Applicant expresses concern that any trauma it is currently receiving, albeit of lower medical intensity, may also be directed away and have a deleterious impact on the Applicant. The Applicant projects no substantial impact on the existing designated trauma facilities.

21.) Please identify the derivable operating efficiencies, if any, (i.e., economies of scale or substitution of capital for personnel) which may result in lower total or unit costs as a result of this proposal.

The design of the EU addition incorporated a CT scanner within the EU to improve the efficiency of the care of the trauma patient. Rather than the need to hire CT technologists, operation of this section can be accomplished with only the addition of transport staff. As well, the design incorporated workflow by area of acuity to improve efficiency and oversight of patient care. The Project as a whole has the potential to save healthcare dollars by stabilizing / treating lower level (i.e., not Level II or Level I) patients, less costly setting. Finally, fuel costs will be reduced by the local communities by not having to travel to a Level I center for a Level III trauma emergency.

22.) Please describe on a separate sheet of paper all energy considerations incorporated in this proposal.

See Exhibit 22 for energy efficiency letter.

23.) Please comment on the affordability of the proposal, specifically addressing the relative ability of the people of the state to pay for or incur the cost of the proposal, at the time, place and under the circumstances proposed. Additionally, please include in your discussion the consideration of the state's economy.

Despite weakening in relation to some of its neighboring states over the past decade, the Rhode Island economy has regained certain strengths in the last few years. Examples include:

- **Substantial growth in economic output since 2010, paralleling states like Massachusetts and Vermont;**
- **Maintaining the level of worker output in comparison to other New England states where it has fallen;**
- **Steadily decreased unemployment over the past decade; and**
- **Increased the average wage steadily during that same period.**

RI is home to at least 5 major industry groups with promising growth opportunities including Biomedical Innovation, IT and Data Analysis, Defense, Advanced Business Design and Advanced Business Services. Although challenges clearly exist, many indicators have improved over the last decade. Moreover, the state has been diligent at laying a foundation for the future. In New England, it is rivaled only by Massachusetts in terms of R&D investment.

Healthcare has traditionally been one of the strongest growth sectors in the state and continues to be so. Although some signs of weakness have been noted in the acute care sector (e.g., acute care occupancy rates as discussed above), the sector overall continues to grow.

The proposed project will contribute to the strengthening of the Rhode Island economy in several ways:

- **It will increase net state revenues for its acute care health system by attracting patients from across the border in Massachusetts. Roughly 60% the project's projected volume will be residents of Massachusetts resulting in additional revenues of $5,541,000 introduced in the state.**
- **It will help to maintain the size and stability of the state's acute care system by adding appropriate inpatient admissions**
- **In connection with the above, it will help to avoid unnecessary decline in that system – avoiding layoffs and other economic disruptions**
- **Finally, and perhaps most importantly, the proposed trauma center will improve outcomes for patients resulting in a preservation of working potential and productivity and preservation of a strong workforce.**

24.) Please address how the proposal will support optimizing health system performance with regards to the following three dimensions:

a. **Improving the patient experience of care (including quality and satisfaction)**

In 2004, U.S. Department of Transportation, National Highway Traffic Safety Administration and the American Trauma Society undertook a joint initiative to spur the expansion of the nation's trauma care system. To initiate this effort, they undertook a study to document the benefits of such an effort. This study, entitled Trauma System: Agenda for the Future. This landmark study summarized the benefits of a more robust trauma treatment system in the U.S.:

> **"The benefits of successful implementation of this plan include: (1) a reduction in deaths caused by trauma; (2) a reduction in the number and severity of disabilities caused by trauma; (3) an increase in the number of productive working years seen in America through reduction of death and disability; (4) a decrease in the costs associated with initial treatment and continued rehabilitation of trauma victims; (5) a reduced burden on local communities as well as the Federal government in support of disabled trauma victims; and (6) a decrease in the impact of the disease on "second trauma" victims – families."**

The proposed project will improve the patient experience by making trauma care more accessible to patients in the service area. This will ensure that more victims of trauma are treated at facilities that specialize in the rapid treatment of injury leading in turn to better outcomes and reduced disability. Such results represent significant improvements in quality and satisfaction with the care received.

Furthermore, as noted above, care and quality will also be improved for special populations including translation services and culturally friendly care processes.

Finally, the program will provide public education in trauma awareness. In part this education will focus on safety behaviors but it will also include education on how to proceed in the event of a trauma. The knowledge of the mechanisms of obtaining care in a crisis will facilitate appropriate action.

b. **Improving the health of populations; and**

As the findings quoted above suggest, the proposed project will enhance the health status of area residents by reducing mortality and disability. As noted in response to Question 7b above, trauma center treatment can reduce mortality by as much as 25%. These benefits accrue within a population from year to year creating a meaningful impact both to individuals and to the overall health status of the communities affected.

c. **Reducing the per capita cost of health care**

At present, trauma care is provided to area residents by Level I & II centers located in Boston, Worcester and Providence. While problems in availability and access to these facilities have been discussed above, it should also be noted that many of these patients

do not require this greater level of care and need not incur the additional costs that can be incurred. The proposed facility will provide for rapid stabilization of all patients and transfer only when known to be necessary for those patients requiring a greater level of care. While actual volumes cannot be known beforehand in any given year, it is reasonable to assume that a meaningful number of patients will avoid the more costly services of the existing providers that are primarily located within the area's largest teaching facilities. This in turn, will lower the average cost of trauma care for residents of the target area.

25.) Please identify any planned actions of the applicant to reduce, limit, or contain health care costs and improve the efficiency with which health care services are delivered to the citizens of this state.

The proposed program will positively impact the cost of trauma care by reducing the average cost of trauma care within the target service area. Trauma Centers are required to provide comprehensive evaluation and stabilization of each patient prior to the initiation of definitive treatment. As a Level III facility, the proposed program will not provide certain services available at Level I facilities such as neurosurgery and certain other surgical subspecialties. The facility will however have the capacity to identify those patients in need of these services as well as the capability of rapid transfer to a facility which does possess them. This will avoid unnecessary duplication and help to restrain costs in the area. Moreover, as described above, the implementation of the new center will enable lower cost trauma care for patients for whom it is appropriate. Finally, the proposed project will improve the efficiency of trauma care in the area by enhancing accessibility and access and reducing the barriers to care.

QUALITY, TRACK RECORD, CONTINUITY OF CARE, AND RELATIONSHIP TO THE HEALTH CARE SYSTEM

26.) **A) If the applicant is an existing facility:**

Please identify and describe any outstanding cited health care facility licensure or certification deficiencies, citations or accreditation problems as may have been cited by appropriate authority. Please describe when and in what manner this licensure deficiency, citation or accreditation problem will be corrected.

Applicant is preparing a Corrective Action Plan in response to a letter, dated December 27, 2016 from the Rhode Island Department of Health. The letter was drafted after a December 9, 2016 on-site inspection.

B) If the applicant is a proposed new health care facility:

Please describe the quality assurance programs and/or activities which will relate to this proposal including both inter and intra-facility programs and/or activities and patient health outcomes

analysis whether mandated by state or federal government or voluntarily assumed. In the absence of such programs and/or activities, please provide a full explanation of the reasons for such absence.

C) If this proposal involves construction or renovation:

Please describe your facility's plan for any temporary move of a facility or service necessitated by the proposed construction or renovation. Please describe your plans for ensuring, to the extent possible, continuation of services while the construction and renovation take place. Please include in this description your facility's plan for ensuring that patients will be protected from the noise, dust, etc. of construction.

Construction of the new Emergency Unit addition will occur in such a way as to allow current EU functions to be maintained without significant disruption. While the addition is being built the current EU public entrance will need to be modified to allow access. This will be achieved by construction of a temporary portal which will safely allow prospective patients to enter the existing EU for care. The ambulance entrance will not be affected. Once the addition is complete access to the EU will be through new separate public and ambulance entrances.

An interim life safety assessment will be conducted on a daily basis to assure a safe environment for patients, visitors and employees. Temporary construction partitions, that are smoke tight and built of non-combustible materials (metal stud and gypsum wall board) that will not contribute to the development or spread of fire, will be utilized to minimize dust and noise from the construction zones.

27.) Please discuss the impact of the proposal on the community to be served and the people of the neighborhoods close to the health care facility who are impacted by the proposal.

As a Level III Trauma Center, the role of the proposed program will be to provide rapid assessment and stabilization of the victim and ongoing treatment if capabilities permit. If more specialized treatment is required, but unavailable at LMC, patients will be stabilized then speedily transferred to a Level I or Level II facility. The proposed program will establish and maintain ongoing consultation and transfer processes with facilities having both lesser and greater capabilities and will serve as an extension of, or "entrance to", Levels I & II Centers in the area.

As noted previously, a large pereentage of patients requiring speeialized trauma care do not dcpendably receive it. The proposed project is designed to make DTC services more accessible to a substantial geographic area encompassing portions of Rhode Island and nearby Massachusetts - an area of almost 1,000 square miles. At present there are no Level I–III Trauma Centers located within this area. Patients must travel to facilities in Boston, Worcester and Providence.

Travel studies show that LMC's location provides distinct advantages in time-to-treatment for trauma cases arising within the target area.

Landmark is located less than 2 miles from the Massachusetts / Rhode Island border. Because trauma victims enjoy a survival advantage by obtaining care as quickly as possible, many trauma victims residing in MA, are likely to seek trauma care at LMC. Given the indirect nature of the road systems serving nearby MA residents, drive times - as opposed to mileage - are the best indicator of travel advantage. Applicant identified 24 MA towns in close proximity to LMC and reviewed travel times to trauma centers in Providence, Worcester and the Boston area. Applicant concluded that residents of 15 of these towns would have a propensity to seek trauma care at LMC given faster, less trafficked routes. The results of this review are provided in the table below.

Trauma Care Travel Study - 9/2016

	TOWN	TIME ADV.*	COMMENT	INC?**
1	Wrentham	6	Freq Heavy Traffic	Y
2	Foxborough	-3	Freq Heavy Traffic	Y
3	Mendon	16		Y
4	Hopedale	17		Y
5	Norfolk	10		Y
6	Uxbridge	1		Y
7	Upton	8		Y
8	Hopkington	-4	Freq Heavy Traffic	Y
9	Holliston	3		Y
10	Medway	13		Y
11	Millis	14		Y
12	Franklin	10		Y
13	Bellingham	17		Y
14	Blackstone	16		Y
15	Millville	15		Y
16	No. Attleboro	3	High pref RIH	N
17	Plainville	1	High pref RIH	N
18	Marshfield	9	Boston Pref.	N
19	Stoughton	7	Boston Pref.	N
20	Sharon	-2		N
21	Northbridge	-13		N
22	Sutton	-18		N
23	Grafton	-18		N

*Time Advantage (explained below).

**Inc.? means included or excluded in this proposal because of drive time estimates, traffic, delays or strong market associations with one or more competing trauma centers.

As a Level III facility, the proposed project will assure that more trauma patients obtain timely assessment, stabilization and rapid initiation of care at LMC or at a facility with greater capabilities as necessary. That is, even for many of those patients who will require transfer elsewhere for definitive treatment, LMC will provide the fastest path to stabilization and the greatest assurance of an optimal outcome.

The Travel Time Study prcsented in the response to Question 27 above was developed as follows:

The Applicant identified those Trauma Centers located in closest proximity to its Targeted Service Area. These include the scven facilities listed in response to Question 7B. As indicated, they range in distance from LMC from 15 to 51 miles. These seven facilities were considered by the Applicant to be potential alternative trauma care providers. Distance was measured in minutes (i.e., drive times).

The Applicant subsequently surveyed the area to identify those towns that visually appeared to be potentially closer in drive times to LMC than to any alternative providers. This resulted in a list of potential service area towns. This review included consideration of alternative providers in each of the Worcester, Boston and Providence areas.

Actual drive times were then obtained from Google Maps for the distance between each potential service area town and LMC and between each town and the closest alternative provider or providers to that town. This analysis was used to determine if LMC was associated with a drive time advantage (+) or disadvantage (-) for each potential town. The results of this analysis is listed under the "Time Advantage" column of the chart provided in the answer to Question 27. This column includes all towns considered and lists the results regardless of whether a drive time advantage to LMC was or was not identified.

Subsequently the Applicant reviewed all of the "potential towns" included in the analysis to determine if their travel routes to the closest Trauma Center – whether LMC or other- would be subject to frequent heavy travel conditions. In some cases, despite the finding of a small travel time disadvantage to LMC (less than 4 minutes), some towns were included in the service area because their alternate routes of travel would frequently involve heavy traffic. At other times, towns were not included in the targcted service area because these towns were thought to have very heavy concentrations of services affiliated with one or more of thc alternative providcrs. While cxclusion of these towns is not entirely logical, the Applicant believed that this approach would hclp to ensure the conservative nature of the project's volume estimates. The determination to include or exclude a town in the Target Service Area is designated with a Y or N placed in the column labeled "INC?" The towns constituting the final projected service area for the project are those with a Y designation in this column.

There are some potential travel time savings for residents of all Rhode Island towns in the projected service area. It should be noted that greater likelihood of heavy traffic may lengthen these times especially for drives to RIH. These times were obtained from Google Maps.

Drive Time Differences Between RIH and LMC for RI Residents				
		To LMC	To RIH	Minutes Saved
RI	Woonsocket	8*	24	+16
RI	Burrillville	27	36	+9
RI	Cumberland	22	15	+7
RI	Glocester	34	31	+3
RI	Lincoln	20	18	+2
RI	N. Smithfield	10	16	+6
*Estimated Avg. Drive Time for Woonsocket Residents				

28.) Please discuss the impact of the proposal on service linkages with other health care facilities/providers and on achieving continuity of patient care.

Qualification as an ACOS certified Trauma Center entails a number of specific activities designed to promote coordinated care and continuity.

Prominent examples include:

- **Transfer Agreements: Trauma Centers must maintain comprehensive transfer agreements with both other Trauma Centers and general hospital emergency rooms. These agreements must contain provisions to ensure ongoing communication and joint planning as well as detailed transfer protocols.**
- **Trauma Centers must conduct community education about trauma and must work in conjunction with other area providers.**
- **Trauma Center management (e.g. The Trauma Center Manager and Trauma Center Director) must participate in regional policy and planning groups and forums and play an active role in regional trauma planning.**
- **Discharge after treatment as with most hospitalizations requires a detailed discharge plan including communication with the patient's primary physician and with providers to whom the patient is referred for follow-up.**

29.) Please address the following:

A. How the applicant will ensure full and open communication with their patients' primary care providers for the purposes of coordination of care;

A patient's primary care provider is contacted in the course of all emergency admissions to Landmark. The purpose of this contact is both to inform the provider of his/her patient's conditions but also to gather information and consultation

regarding the patients. Primary care providers are briefed and consulted as appropriate regarding major developments in the case and advised upon discharge. Patients lacking a primary care provider will be urged to establish such a relationship upon discharge and the hospital will supply referrals and necessary and make all necessary records available to promote coordination of care.

B. Discuss the extent to which preventive services delivered in a primary care setting could prevent overuse of the proposed facility, medical equipment, or service and identify all such preventative services;

The primary role of preventative services with respect to trauma care is public education regarding safe behavior when engaged in activities associated with trauma such as automobile transportation, operating machinery, performing household chores and avoiding poisons. As noted below, the trauma center will make public education available to service area residents including education tailored to special populations. One aspect of this education will include printed educational materials to be distributed to patients directly, through various organizations and through the area's network of primary care physicians.

C. Describe how the applicant will make investments, parallel to the proposal, to expand supportive primary care in the applicant's service area.

The primary investment to be made by LMC to promote supportive trauma care from the primary care perspective are the education programs and materials described above.

D. Describe how the applicant will use capitalization, collaboration and partnerships with community health centers and private primary care practices to reduce inappropriate Emergency Room use.

Inappropriate emergency room care is largely the function of inappropriate decisions or a lack of alternatives for patients. Trauma care, unlike routine emergency room care has little if any discretionary element. Trauma patients typically do not have a less intensive alternative. They require rapid expert assessment and assessment and treatment which are typically only available at a trauma center.

The Applicant encourages appropriate general emergency room treatment in its normal operations by promoting a robust primary care network in its area and providing public education on the appropriate use of the emergency room.

E. Identify unmet primary care needs in your service area, including "health professionals shortages", if any (information available at Office of Primary Care and Rural Health at (http://www.health.ri.gov/programs/primarycareandruralhealth/).

Landmark is located in the City of Woonsocket, RI – a medical manpower shortage area of longstanding. While LMC has long made efforts to support the growth and

development of primary care in the city (and has an excellent working relationship with Thundermist, the area's Community Health Center), the area's poor economy and lack of insurance coverage make long term advances difficult to sustain. Landmark continues to address this issue.

30.) Please discuss the relationship of the services proposed to be provided to the existing health care system of the state.

The relationship between the proposed project and Rhode Island's existing health services is described by the following factors:

1. **Strengthening Acute Care: Recent trends in annual acute care admissions have been cause for concern about the continued strength of our state's hospital system. Any program that counters this trend to any degree will obviously help to avoid loss of hospital beds and services. As already noted, this program will bring both inpatients and outpatients into Rhode Island from Massachusetts and help to preserve RI's long standing advantage as a net importer of hospitals care.**

2. **Working Cooperatively with the Level I Trauma Center: The services to be provided by this proposal are only available at one other facility in the state, i.e., Rhode Island Hospital in Providence. While some overlap exists in service area between Rhode Island Hospital & LMC, given its location the proposed DTC at LMC will reach much farther into the Massachusetts market than RIH. Moreover, because some patients initially treated at the proposed facility (Level III) will require additional treatment at a Level I facility (RI) LMC has the potential to direct such patients to RIH as appropriate. An important element of the proposed program will be to establish a well-coordinated referral and communication program with RIH to best serve our prospective patients. The Applicant believes that the proposed program will benefit and strengthen the existing Trauma Center at RIH.**

3. **Providing Unique Services: Finally, the proposed program will have no adverse impacts on other hospitals in the state. This is true both because the services offered will be unique as well as the fact that a large number of the patients serviced lie beyond the areas served by the state's other acute care providers.**

31.) Please identify any state or federal licensure or certification citations and/or enforcement actions taken against the applicant and their affiliates within the past 3 years and the status or disposition of each.

None

32.) Please provide a list of pending or adjudicated citations, violations or charges against the applicant and their affiliates brought by any governmental agency or accrediting agency within the past 3 years and the status or disposition of each.

See Exhibit 32 for reports filed with Rhode Island Office of Attorney General as a condition of approval of Applicant's hospital application. In addition, Applicant is drafting a Corrective Action Plan that will be responsive to the December 27, 2016 letter from the Rhode Island Department of Health.

33.) Please provide a list of any investigations by federal, state or municipal agencies against the applicant and their affiliates within the past 3 years and the status or disposition of each.

See Exhibit 33 for a press release reporting the ongoing Department of Justice investigation concerning Applicant's parent's California hospitals.

Select and complete the Appendixes applicable to this application:

Appendix	Check off:	Required for:
A		Accelerated review applications
B	√	**Applications involving provision of services to inpatients**
C		Nursing Home applications
D	√	**All applications**
E	√	**Applications with healthcare equipment costs in excess of $2,451,805 and any tertiary/specialty care equipment**
F		Applications with debt or lease financing
G	√	**All applications**

Appendix B

Provision of Health Services to Inpatients

1. Are there similar programmatic alternatives to the provision of institutional health services as proposed herein which are superior in terms of:

   a. Cost ___ **Yes** _X_ **No**
   b. Efficiency ___ **Yes** _X_ **No**
   c. Appropriateness ___ **Yes** _X_ **No**

2. For each No response in Question 1, discuss your finding that there are no programmatic alternatives superior to this proposal separately for each such finding.

   a. **Cost: The Applicant considered the alternative of developing a Trauma Center of greater capability. Development of a Level I and Level II facility. Either of these alternatives would be more costly than the proposed project given the need to add additional capability and resources.**

   b. **Efficiency: The Applicant concluded that the proposed alternative would provide maximum efficiency by improving the time to treatment and stabilization for trauma victims throughout the area while at the same time providing for rapid access to a Level I or II Trauma Center for those patients requiring these services.**

   c. **Appropriateness: The Applicant can identify no alternative that would respond to the area need as well as the proposed project without adding unnecessary development cost or requiring many patients to be treated at a level of care that is not necessary.**

3. For each Yes response in Question 1, identify the superior programmatic alternative to this proposal, and explain why that superior alternative was rejected in favor of this proposal separately for each such finding.

4. In the absence of proposed institutional health services proposed herein, will patients encounter serious problems in obtaining care of the type proposed in terms of:

   a. Availability ___ Yes _X_ No
   b. Accessibility ___ Yes _X_ No
   c. Cost ___ Yes _X_ No

5. For each Yes response in Question 4, please justify and provide supporting evidence separately for availability, accessibility and cost.

   a. Availability ___ Yes _ _ No
   b. Accessibility ___ Yes _ _ No
   c. Cost ___ Yes _ _ No

Appendix D

All applications must be accompanied by responses to the questions posed herein.

1. Provide a description and schematic drawing of the contemplated construction or renovation or new use of an existing structure and complete the Change in Space Form.

   We propose to construct a single story, 13,700 sq. ft. addition on the east side of the campus, adjacent to the existing Emergency Department. Please refer to the site and floor plans attached to this submission at Exhibit D.

2. Please provide a letter stating that a preliminary review by a Licensed architect indicates that the proposal is in full compliance with the current edition of the "Guidelines for Design and Construction of Hospital and Health Care Facilities" and identify the sections of the guidelines used for review. Please include the name of the consulting architect, and their RI Registration (license) number and RI Certification of Authorization number.

   Please refer to the Code Compliance letter attached to this submission at Exhibit D.

3. Provide assurance and/or evidence of compliance with all applicable federal, state and municipal fire, safety, use, occupancy, or other health facility licensure requirements.

   Please refer to the Code Compliance letter attached to this submission at Exhibit D.

4. Does the construction, renovation or use of space described herein corrects any fire and life safety, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), U.S. Department of Health and Human Services (DHHS) or other code compliance problems: Yes____ No__X__

   o If Yes, include specific reference to the code(s). For each code deficiency, provide a complete description of the deficiency and the corrective action being proposed, including considerations of alternatives such as seeking waivers, variances or equivalencies.

5. Describe all the alternatives to construction or renovation which were considered in planning this proposal and explain why these alternatives were rejected.

   Landmark Medical Center has experienced a significant increase in the need for emergency services from the surrounding community serviced by the hospital. This has led to the design to attain a Level III Trauma Center designation. The hospital explored expansion opportunities within the built footprint of the hospital. The existing emergency department is bordered by the hospital's imaging department and operating rooms which are vital services that do not have free space available. This has led to the need for a new addition to be built to meet the space and infrastructure requirements for a Level III Trauma Center.

6. Attach evidence of site control, a fee simple, or such other estate or interest in the site including necessary easements and rights of way sufficient to assure use and possession for the purpose of the construction of the project.

See Deed attached to this application at Exhibit D.

7. If zoning approval is required, attach evidence of application for zoning approval.

The hospital is located within a special permit district. All projects are reviewed and approved. The hospital has an ongoing relationship with town zoning officials. This project will not have any difficulties in obtaining zoning approval. Evidence of delivery of the zoning application is attached at Exhibit D.

8. If this proposal involves new construction or expansion of patient occupancy, attach evidence from the appropriate state and/or municipal authority of an approved plan for water supply and sewage disposal.

The campus is currently served by two separate water supply lines that enter the facility at different points. This existing system has more than enough capacity to handle the supply demand that the new addition will create. The existing sewage disposal system on campus also has sufficient capacity to handle the additional volume that will be generated by the proposed project.

9. Provide an estimated date of contract award for this construction project, assuming approval within a 120-day cycle.

The anticipated date for the construction contract to be awarded is January 2018.

10. Assuming this proposal is approved, provide an estimated date (month/year) that the service will be actually offered or a change in service will be implemented. If this service will be phased in, describe what will be done in each phase.

The anticipated date for when services will start is January 2019. The new addition will be built to allow for the existing emergency department to maintain uninterrupted services throughout construction.

Change in Space Form Instructions

The purpose of this form is to identify the major effects of your proposal on the amount, configuration and use of space in your facility.

Column 1
Column 1 is used to identifying discrete units of space within your facility, which will be affected by this proposal. Enter in Column 1 each discrete service (or type of bed) or department, which as a result of this proposal is:

a.) to utilize newly constructed space
b.) to utilize renovated or modernized space
c.) to vacate space scheduled for demolition

In each of the Columns 3, 4, and 5, you are requested to disaggregate the construction, renovation and demolition components of this proposal by service or department. In each instance, it is essential that the total amount of space involved in new construction, renovation or demolition be totally allocated to these discrete services or departments listed in Column 1.

Column 2
For each service or department listed in Column 1, enter in this column the total amount of space assigned to that service or department at all locations in your facility whether or not the locations are involved in this proposal.

Column 3
For each service or department, please fill in the amount of space which that service or department is to occupy in proposed new construction. The figures in Column 3 should sum to the total amount of space of new construction in this proposal.

Column 4
For each service or department, please fill in the amount of space, which that service or department is to occupy in space to be modernized or renovated. The figures in column 4 should sum to the total amount of space of renovation and modernization in this proposal.

Column 5
For each service or department fill in the amount of currently occupied space which is proposed to be demolished. The figures in Column 5 should sum to the total amount of space of demolition specified in this proposal.

Column 6
For each service or department entered in Column 1, enter in this column the total amount of space which will, upon completion of this project, be assigned to that service or department at all locations in your facility whether or not the locations are involved in this proposal.

Column 7
Subtract from the amount of space shown in Column 6 the amount shown in Column 2. Show an increase or decrease in the amount of space.

Change in Space Form Instructions

Please identify and provide a definition for the method used for measuring the space (i.e. gross square footage, net square footage, etc.):

The method used to provide square footage numbers for the project was net square footage.

1. Service or Department Name	2. Current Space Amount Net	3. New Construction Space Amount Net	4. Renovation Space Amount Net	5. Amount of Space Currently Occupied to be Demolished Net	6. Proposed Space Amount Net	7. Change [(6)-(2)] Net
Emergency Department	9,150	13,700	2,760	2,760	15,260	6,110
TOTAL:	9,150	13,700	2,760	2,760	15,260	6,110

Appendix E

Acquisition of Health Care Equipment Valued in Excess of $2,451,805 or Tertiary/Specialty Care Equipment

Complete separate copies of this appendix for each piece of such equipment contained in this application.

1. Identify the proposed equipment (and current if it is being replaced) and at least two similar alternative makes or models that were considered for acquisition in the following format

	Current Equipment	Proposed Equipment	Alternative 1	Alternative 2
Type of Equipment	**N/A**	**CT SCAN**	**Somatom Definition AS Model AS 64**	**Prospective AS 64**
Name of Manufacturer			**Siemens**	**Siemens**
Make and Model Number			**Definition AS 64**	**Prospective**
Capital Cost of Equipment			**$700,000**	**$500,000**
Operating Cost			**$107,944**	**$107,944**

2. Describe the clinical application for which the proposed equipment will be used.

   The CT Scan within the EU will be utilized to assess traumatic damage.

3. Please identify the reasons the alternative two options were rejected in favor of the proposed equipment

   The Somatom CT Scanner has a larger Bore and hence was chosen over the Prospective Scanner.

4. If the proposal is to replace current existing equipment, please provide the following information:

	Current Equipmcnt
Date of Acquisition	**N/A**
Expcctcd Salvage Value	
Remaining Useful Life	
Method of disposition	

5. Please state below the number of new full-time equivalent personnel by job category whom you will hire in order to operate the proposed equipment.

Job Category	Number of FTE's	Payroll Expense
	No additional staff	
Transport	2	$77,388

6. Please describe below your anticipated utilization for this equipment for each of the three fiscal years following acquisition of this equipment.

Fiscal Year	2019	2020	2021
Hours of Operation	24/7	24/7	24/7
Utilization			
Potential Throughput	96/d	96/d	96/d
Utilization Rate (%)			

Appendix G

Ownership Information

All applications must be accompanied by responses to the questions posed herein.

1. List all officers, members of the board of directors, stockholders, and trustees of the licensee, applicant and/or ultimate parent entity. For each individual, provide their home and business address, principal occupation, position with respect to the licensee, applicant and/or ultimate parent entity, and amount, if any, of the percentage of stock, share of partnership, or other equity interest that they hold.

Applicant Board of Directors

NAME	BUSINESS ADDRESS	OCCUPATION	POSITION AS TO APPLICANT	EQUITY
Stanley Balon, MD	175 Nate Whipple Highway, Suite 204 Cumberland, RI 02864	Physician	Physician	None
Peter Bancroft, CPA, CEO	WellOne 36 Bridge Way Pascoag, RI 02859	Accountant	Director	None
Richard Charest, /R.Ph., MBA	115 Cass Avenue Woonsocket, RI 02895	Healthcare Administrator	CEO/President	None
Shaun Cournoyer	Friendly Nursing Home 303 Rhodes Avenue Woonsocket, RI 02895	Assistant Administrator	Director	None
Margie Macek	LMC 115 Cass Avenue Woonsocket, RI 02895	Chief Nursing Officer	Chief Nursing Officer	None
Glenn Fort, MD	LMC 115 Cass Avenue Woonsocket, RI 02895	Chief Medical Officer	Chief Medical Officer	None
Joel Jillson, Fire Chief	North Smithfield Fire Dept. 1470 Providence Pike No. Smithfield, RI 02896	Fire Chief	Director	None
Griegstone Yearwood, MD	191 Social Street #840 Woonsocket, RI 02895	Physician	Physician	None
Gary Reis, CEO	Med Tech Ambulance 290 Armistice Blvd. Pawtucket, RI 02861	Administrator	Director	None

NAME	BUSINESS ADDRESS	OCCUPATION	POSITION AS TO APPLICANT	EQUITY
Normand St. Laurent, FIC, Vice President	Keough Kirby Insurance 68 Cumberland Street P.O. Box I Woonsocket, RI 02897	Insurance	Director	None
Khin Yin, MD, Medical Director	Rehabilitation Hospital of Rhode Island 116 Eddie Dowling Highway North Smithfield, RI 02896	Physician	Director	None

Prime Healthcare Services, Inc. Board of Directors

Name	Business Address	Occupation	Position to Applicant	Equity
Prem Reddy, M.D.	3300 E. Guasti Road	Health Care Administrator	See below	See below
Jack Hunt	1515 Callie Cristina San Dimas, CA 91773	Retired Judge		0
Ted Dutton	Urban Advisors, Inc. 9339 Feron Blvd. Rancho Cucamonga, CA 91730	Urban Planner		0
Greg Hafif	Hafif Family Foundation 4950 Live Oak Canyon Road LaVerne, CA 91750	Attorney		0
Robert Diener	Law Offices of Robert Diener 56 Laenani Street Haiku, HI 96708	Attorney		0

Prem Reddy, M.D. is President and Chief Executive Officer of Prime Healthcare Services, Inc. ("PHSI").

2. For each individual listed in response to Question 1 above, list all (if any) other health care facilities or entities within or outside Rhode Island in which he or she is an officer, director, trustee, shareholder, partner, or in which he or she owns any equity or otherwise controlling interest. For each individual, please identify: A) the relationship to the facility and amount of interest held, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, and F) any professional accreditation (e.g. JACHO, CHAP, etc.).

Gary Reis an owner of Med Tech Ambulance. License: EMS00122. Address: 290 Armistice Blvd., Pawtucket, RI. As to PHSI, Dr. Reddy has a controlling interest of the PHSI hospitals as Grantor of the three KASP Trusts shown on Exhibit G. See the pages that follow for health care facility information.

3. If any individual listed in response to Question 1 above, has any business relationship with the licensee, applicant and/or ultimate parent entity, including but not limited to: supply company, mortgage company, or other lending institution, insurance or professional services, please identify each such individual and the nature of each relationship.

As to Applicant:

- **Dr. Balon and Dr. Yearwood are on the Medial Staff of LMC.**
- **Mr. Charest is President, CEO, and Chair of Applicant.**
- **Ms. Cournoyer is Assistant Administrator of Friendly Nursing Home; LMC discharges patients to this nursing home.**
- **Ms. Macek is Chief Nursing Officer at LMC.**
- **Dr. Fort is Chief Medical Officer at LMC.**
- **Mr. Reis is CEO of Med Tech Ambulance and Med Tech Ambulance and LMC are parties to a contract for ambulance services.**
- **Dr. Yin is Medical Director of RHRI.**

As to PHSI, Dr. Reddy is an employee of Prime Healthcare Management Services, Inc., an entity that provides business support services to Applicant.

4. Have any individuals listed in response to Question 1 above been convicted of any state or federal criminal violation within the past 20 years? Yes___ No _X_.

- If response is 'Yes', please identify each person involved, the date and nature of each offense and the legal outcome of each incident.

5. Please provide organization chart for the applicant, identifying all "parent" entities with direct or indirect ownership in or control of the applicant, all "sister" legal entities also owned or controlled by the parent(s), and all subsidiary entities owned by the applicant. Please provide a brief narrative clearly explaining the relationship of these entities, the percent ownership the principals have in each (if applicable), and the role of each and every legal entity that will have control over the applicant.

See the Organizational Charts of the subsidiary and parent organizations of Prime Healthcare Services, Inc., a California business corporation ("PHSI") and Prime Healthcare Foundation, Inc., a charitable non-stock, Delaware corporation (the "Foundation") at Exhibit G. Prime Healthcare Services – Landmark, LLC, a Delaware corporation (Prime-Landmark) is a subsidiary of PHSI, however, Prime–Landmark has filed a Change of Effective Control application so that its parent corporation will be the Foundation instead. Prime–Landmark then will be a charitable corporation.

6. Please list all licensed healthcare facilities (in Rhode Island or elsewhere) owned, operated or controlled by any of the entities identified in response to Question 5 above (applicant and/or its

principals). For each facility, please identify: A) the entity, applicant or principal involved, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, and F) any professional accreditation (e.g. JACHO, CHAP, etc.).

See following pages.

Prime Healthcare Services, Inc.

License Type	Address	License Number	Medicare Number	Accreditation
pital abilitation	6655 Alvarado Road San Diego, CA 92120	090000013	05-0757 05-T757	Joint Commission
pital abilitation	201 NW R D Mize Road Blue Springs, MO 64014-2513	536-0	26-0193 26T193	Joint Commission
pital abilitation h	555 E. Hardy Street Inglewood, CA 90301	930000027	05-0739 05-T739 05-S739	Joint Commission
pital	5451 Walnut Avenue Chino, CA 91710	240000125	360109	Joint Commission
pital h	7 Medical Parkway Dallas, TX 75234	100214	45-0379 45-S379	Joint Commission
pital	16850 Bear Valley Road Victorville, CA 92395	240000562	05-0709	Joint Commission
pital ging Ctr. . Management h Unit	600 S. 3rd Street Gadsden, AL 35901	13561	01-0046 01-0046 01-S046	Joint Commission
pital (Acute) h abilitation Phys	6245 Inkster Road Garden City, MI 48135	1060000095	23-0244 23-0244 23-T244 23-0244	HFAP
pital	12601 Garden Grove	060000152	05-0230	Joint Commission

Harlingen Medical Center	Hospital	5501 South Expressway 77 Harlingen, TX 78550	007880	45-0855	Joint Commission
St. Joseph Medical Center	Hospital Rehab Rehab-Kansas City Home Health Hospital	1000 Carondelet Drive Kansas City, MO 64114	537-1	26-0085 26-T085 17-7183	Joint Commission
Landmark Medical Center	Hospital Psych	115 Cass Avenue Woonsocket, RI 02895	HOS00131	41-0011 41-S011	Joint Commission
Rehab Hospital of Rhode Island	Rehab Hospital	116 Eddie Dowling Highway North Smithfield, RI 02896	RHC 02103	41-3025	Joint Commission
Lehigh Regional Medical Center	Hospital	1500 Lee Boulevard Lehigh Acres, FL 33936	1060000015	10-0107	Joint Commission
Lower Bucks Hospital	Hospital Psych Home Health Residency Program	501 Bath Road Bristol, PA 19007	703205	39-0070 39S070 39-7032 39-0077	Joint Commission
Dallas Regional Medical Center	Hospital	1011 N. Galloway Avenue Mesquite, TX 75149	100292	45-0688	Joint Commission
Monroe Hospital	Hospital	4011 S. Monroe Medical Park Blvd. Bloomington, IN 47403	15-004287-1	15-0183	Joint Commission

Paradise Valley Hospital	Hospital Psych Rehab	2400 East 4th Street National City, CA 91950	649HOS-34	05-0024 05-S024 05-T204	NIAHO
Lake Huron Medical Center	Hospital Rehab	2601 Electric Avenue Port Huron, MI 48060-6587	1060000015	23-0031 02-3T031	Joint Commission
Providence Medical Center	Hospital	8929 Parallel Parkway Kansas City, KS 66112	H-105-003	17-0146	Joint Commission
Saint Mary's Regional Medical Center	Hospital Rehab Hospice Home Health	235 W. 6th Street Reno, NV 89503	658HOS-28	29-0009 29-T009 29-1501 2-7008	Joint Commission
Roxborough Memorial Hospital	Hospital Psych Rehab	5800 Ridge Avenue Philadelphia, PA 19128	910401	39-0304 39-S304 39-T304	Joint Commission
Saint John Hospital	Hospital Psych	3500 South Fourth Street Leavenworth, KS 66048-5092	H-052-002	17-0009	Joint Commission
St. Mary's General Hospital	Hospital	350 Boulevard Passaic, NJ 07055	11606	31-0006	Joint Commission
Saint Clare's Denville Hospital	Hospital Psych	25 Pocono Road Denville, NJ 07835	11406	31-0050 4473322	Joint Commission
Saint Clare's Dover Hospital	Hospital	400 West Blackwell St. Dover, NJ 07801	11402	31-0050	Joint Commission
Saint Clare's Hospital – Boonton	Hospital	130 Powerville Road Boonton Township, NJ 07005	21403	31-S050	Joint Commission
Saint Clare's Sussex Health Center	Ambulatory Care	20 Walnut Street Sussex, NJ 07054	1351	31-0050	Joint Commission

Saint Clare's Imaging Center at Parsippany	Ambulatory Care	3219 Route 46 East Parsippany, NJ 07054	1200	31-0050	Joint Commission
Saint Clare's Health System-Lakeland Cardio Center	Ambulatory Care	765 Route 10 Suite 104 Randolph, NJ 07869	24851 & 24852	31-0050	Joint Commission
Skilled Nursing-The Dwelling Place	SNF	400 W. Blackwell St. Dover, NJ 07801	NJ11402L	31-5019	Joint Commission
Visiting Nurse Association of Saint Clare's	Home Health	191 Woodport Rd. Suite 203A Sparta, NJ	71902	31-7076	Joint Commission
St. Michael's Medical Center	Hospital	111 Central Avenue Newark, NJ 07109	10713	31-0096	Joint Commission
San Dimas Community Hospital	Hospital SNF	1350 W. Covina Boulevard San Dimas, CA 91773	930000139	05-0588 55-5643	Joint Commission
Shasta Regional Medical Center	Hospital Psych	1100 Butte Street Redding, CA 96001	230000023	05-0764	Joint Commission
West Anaheim Medical Center	Hospital Psych SNF	3033 West Orange Avenue Anaheim, CA 92804	060000182	05-5529 05-S426 55-5883	Joint Commission

Prime Healthcare Foundation – Hospitals

Facility Name	License Type	Address	License Number	Medicare Number	Accreditation
Coshocton Regional Medical Center	Hospital	1460 Orange Street Coshocton, OH 43812	1129	36-0109	Joint Commission
Encino Hospital Medical Center	Hospital Psych Rehab	16237 Ventura Boulevard Encino, CA 91436	930000051	05-0158 05-S158 05-T158	Joint Commission
East Liverpool City Hospital	Hospital	425 West 5th Street East Liverpool, OH 43920	RN62833	36-0096	Joint Commission
Glendora Community Hospital	Hospital Psych	150 West Route 66 Glendora, CA 91740	930000060	05-0205 05-S205	Joint Commission
Huntington Beach Hospital	Hospital Psych	17772 Beach Boulevard Huntington Beach, CA 92647-6819	0600000124	05-0526 05-S526	Joint Commission
Knapp Medical Center	Hospital	1401 East 8th Street Weslaco, TX 78596	000480	45-0128	Joint Commission
La Palma Intercommunity Hospital	Hospital Psych Rehab	7901 Walker Street La Palma, CA 90623	060000136	05-0580 05-S580 05-T580	Joint Commission
Montclair Hospital Medical Center	Hospital	5000 San Bernardino Street Montclair, CA 91763	240000141	05-0758	Joint Commission
Pampa Regional Medical Center	Hospital Psych	One Medical Plaza Pampa, TX 79065	100154	45-0099 45-S099	Joint Commission

Sherman Oaks Hospital	**Hospital** **Psych** **SNF** **SAGE**	**4929 Van Nuys Blvd. Sherman Oaks, CA 91403**	**930000149**	**05-0755** **05S55**	**Joint Commission**
Southern Regional Medical Center	**Hospital** **Rehab**	**11 Upper Riverdale Rd Riverdale, GA 30274**	**031-442**	**11-0164** **11-T165**	**Joint Commission**
Suburban Community Hospital	**Hospital** **Behavioral Health** **SPU Unit**	**2701 Dekalb Pike Norristown, PA 19401**	**197201**	**39-0116** **39-S116** **39-0116**	**Joint Commission**
Huntington Beach Hospital	**Hospital** **Psych**	**17772 Beach Boulevard Huntington Beach, CA 92647-6819**	**0600000124**	**05-0526** **05-S526**	**Joint Commission**

7. Have any of the facilities identified in Question 5 or 6 above had: A) federal conditions of participation out of compliance, B) decertification actions, or C) any actions towards revocation of any state license? Yes ___ No X .

   - If response is 'Yes', please identify the facility involved, the nature of each incident, and the resolution of each incident.

8. Have any of the facilities owned, operated or managed by the applicant and/or any of the entities identified in Question 5 or 6 above during the last 5-years had bankruptcies and/or were placed in receiverships? Yes___ No X

   - If response is 'Yes', please identify the facility and its current status.

9. For applications involving establishment of a new entity or involving out of state entities, please provide the following documents:

   - Certificate and Articles of Incorporation and By-Laws (for corporations)
   - Certificate of Partnership and Partnership Agreement (for partnerships)
   - Certificate of Organization and Operating Agreement (for limited liability corporations)

   See Exhibit G for current Prime-Landmark Certificate and Operating Agreement.

pls put colored pgs between.

TRANSFER AGREEMENT
BETWEEN
RHODE ISLAND HOSPITAL
AND
PRIME HEALTHCARE SERVICES – LANDMARK, LLC

This Transfer Agreement (the "Agreement") is entered into by and between RHODE ISLAND HOSPITAL, 593 Eddy St., Providence, RI 02903, and PRIME HEALTHCARE SERVICES – LANDMARK, LLC, a Delaware Limited Liability Corporation, with offices at 3300 E. Guasti Road, 3rd Floor, Ontario, CA 91761, on behalf of its hospital facility known in Rhode Island as LANDMARK MEDICAL CENTER, located at 115 Cass Avenue, Woonsocket, RI 02895 (collectively hereinafter, the "Hospitals") this 23rd day of January, 2017 (the "Effective Date").

WHEREAS, the parties desire to facilitate continuity of care and appropriate transfer of patients to or from either Hospital; and

WHEREAS, the Hospitals have determined that it would be in the best interest of their patients and it would promote exemplary patient care to enter into a transfer agreement documenting the process of transfer of patients between the respective Hospitals;

NOW THEREFORE, in the interest of optimum patient care and in consideration of the mutual advantages to be obtained, the parties agree as follows:

1. PURPOSE OF AGREEMENT

Each Hospital agrees to receive from the other Hospital patients in need of the care provided by their respective Hospitals for the purpose of providing improved patient care and continuity of patient care and to execute such transfers in accordance with applicable federal and state laws, including without limitation, the Federal Emergency Treatment and Active Labor Act, 42 U.S.C. 1395dd and regulations promulgated therefrom, as amended from time to time ("EMTALA").

2. INITIATION OF TRANSFER

a. If an Attending Physician at either of the Hospitals (the "Transferring Hospital") determines that the transfer of a patient to the other hospital (the "Receiving Hospital") is medically required or appropriate and in accordance with EMTALA and other applicable federal and state laws governing the transfer of patients.

b. The Receiving Hospital shall agree to receive the patient as promptly as possible, provided that resource space is available to accommodate that patient. No transfer shall be made until the Receiving Hospital has advised the Transferring Hospital that adequate facilities will be available for the patient at the time of transfer.

c. The Transferring Hospital shall complete a generally accepted transfer form in accordance with state and federal law and forward it to the Receiving Hospital, along with all documentation of physician and nursing care, diagnostic and laboratory testing and any other information requested by the Receiving Hospital.

3. TRANSFER OF PATIENT

a. All patient transfers pursuant to this Agreement shall be made in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission ("TJC") and other applicable accrediting bodies, as well as the applicable policies and procedures of the parties.

b. The Transferring Hospital is responsible for assuring that a patient with an emergency medical condition or in active labor is stable and/or the transfer benefits outweigh the risks prior to transfer. The Transferring Hospital agrees to provide for the safe management of the patient during transportation, including blood volume replacement, monitoring of vital signs, use of medications ordered by the physician, and sufficient equipment and staff to care for the patient.

c. The Transferring Hospital shall obtain written consent to the transfer from the patient or the patient's representative prior to the transfer, except in the case of an emergency in which a delay of the transfer might further endanger the health of the patient.

d. The Transferring Hospital shall be responsible for arranging and facilitating the transfer of the patient up to the point of arrival at the Receiving Hospital, including arranging for appropriate and safe transportation and care of the patient during the transfer and assuring appropriate health care practitioner(s) accompany the patient.

e. The Transferring Hospital shall be responsible for the transfer or other appropriate disposition of personal effects, particularly money and valuables, and information related to these items.

f. The Receiving Hospital's responsibility for the patient's care shall begin when the patient is registered with the Emergency Department or admitted, either as an outpatient or inpatient, to that Hospital.

g. As appropriate to the patient's care and agreed to by the Hospitals, the Receiving Hospital may arrange to transport the patient and in so doing, shall provide appropriate personnel to accompany the patient; in these situations, the Receiving Hospital's responsibility for the patient's care begins when the patient enters the transport vehicle at the Transferring Hospital's premises.

4. RETURNS

The Transferring Hospital agrees that it will accept transfers back from the Receiving Hospital should: i) the original patient consent; ii) there is a mutual discussion and determination by physicians at both Hospitals that the patient is stable for transfer; and iii) that the appropriate physical and professional resources are available for the returning patient at the original transferring Hospital.

5. BILLING

Charges for services performed by either Hospital shall be collected by the Hospitals rendering such services, directly from the patient and/or responsible person or agency as normally billed by the Hospital; neither Hospital shall have any liability to the other for such charges.

6. AMENDMENT

This Agreement may be modified or amended at any time by mutual agreement of the authorized officials of both Hospitals. Any modification or amendment shall be agreed to in writing between the parties.

7. TERM

The Term of this Agreement shall commence on the day and year first written above and shall continue for a period of one year, and thereafter it shall be renewed automatically for successive periods of one (1) year, unless sooner terminated as hereinafter provided.

8. TERMINATION

a. Voluntary Termination. This Agreement may be terminated by either Party for any reason, by giving thirty (30) days' prior written notice of its intention to withdraw from this Agreement, and by ensuring the continuity of care to patients who already are involved in the transfer process. To this end, the terminating Party will be required to meet its commitments under this Agreement for all patients for whom the other Party has begun the transfer process in good faith.

b. Involuntary Termination. This Agreement shall be terminated immediately upon the occurrence of any of the following:

i. either Hospital is destroyed to such an extent that the patient care provided by such Hospital cannot be carried out accurately;

ii. either Hospital loses its license or accreditation; or

iii. either Hospital no longer is able to provide the service for which this Agreement was sought.

9. ASSIGNMENT

Neither party may assign this Agreement in whole or in part, without the prior written consent of the other party.

10. GOVERNING LAW

This Agreement shall be governed by and construed in accordance with the laws of the State of Rhode Island.

11. INDEPENDENT CONTRACTOR STATUS AND INSTITUTIONAL AUTONOMY

Both Hospitals are independent contractors and the Governing Body of each Hospital shall have exclusive control of policies, management, assets, and affairs of its respective Hospital. Neither Hospital is authorized or permitted to act as an agent or employee of the other. Furthermore, each Hospital shall be responsible for its own acts and omissions in the performance of their duties under this Agreement, including the acts and omissions of its own employees and agents.

12. NON-DISCRIMINATION

In performing their obligations under this Agreement, the parties shall not discriminate against any individual because of race, color, national origin, ancestry, age, sex, religion, physical or mental handicap, or sexual orientation. The parties agree to comply with all applicable Federal and State statutes, rules and regulations prohibiting discrimination including but not limited to: Title VII of the Civil Rights Act of 1964; the Age Discrimination in Employment Act of 1967; Section 504 of the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990; and M.G.L. C.151B.

13. INSURANCE

Each party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance coverage, with minimum limits of liability of $2 million per occurrence/$6 million aggregate.

14. MISCELLANEOUS

Any notices or other communications required or permitted by this Agreement shall be given in writing and delivered by personal delivery, mail, certified mail, overnight courier, or facsimile and forwarded to the following individuals at the addresses listed at the end of this Agreement. No partial invalidity of this Agreement shall affect the remainder. This Agreement constitutes the entire agreement of the parties with respect to the subject matter hereof. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other hospital or nursing home, on either a limited or general basis while this Agreement is in effect.

IN WITNESS THEREOF, the parties hereto have duly executed this Agreement as of the first date stated above.

RHODE ISLAND HOSPITAL

By: Margaret M. Van Bree

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RESOURCES

COMMITTEE ON TRAUMA
AMERICAN COLLEGE OF SURGEONS

100+

Resources for Optimal Care of the Injured Patient

is intended as an instructive tool to assist surgeons and health care institutions in improving the care of injured patients. It is not intended to replace the professional judgment of the surgeon or health care administrator in individual circumstances. The American College of Surgeons and its Committee on Trauma cannot accept, and expressly disclaim, liability for claims arising from the use of this work.

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Primary Editors

Supplemental Readings

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Criteria Quick Reference Guide

The preceding chapters of *Resources for Optimal Care of the Injured Patient* are designed to clearly define the criteria to verify that trauma centers have resources for optimal care of injured patients.	**This chapter is included as a quick reference to identify the criteria to meet the requirements as stated in each chapter.**

Chapter	Level	Criterion by Chapter and Level	Type
Chapter 1: Trauma Systems			
1	I, II, III, IV	The individual trauma centers and their health care providers are essential system resources that must be active and engaged participants (CD 1–1).	TYPE II
1	I, II, III, IV	They must function in a way that pushes trauma center–based standardization, integration, and PIPS out to the region while engaging in inclusive trauma system planning and development (CD 1–2)	TYPE II
1	I, II, III, IV	Meaningful involvement in state and regional trauma system planning, development, and operation is essential for all designated trauma centers and participating acute care facilities within a region (CD 1–3)	TYPE II
Chapter 2: Description of Trauma Centers and Their Roles in a Trauma System			
2	I, II, III, IV	This trauma center must have an integrated, concurrent performance improvement and patient safety (PIPS) program to ensure optimal care and continuous improvement in care (CD 2–1).	TYPE I
2	I, II, III	Surgical commitment is essential for a properly functioning trauma center (CD 2–2).	TYPE I
2	I, II, III, IV	Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification (CD 2–3).	TYPE II
2	I	A Level I trauma center must admit at least 1,200 trauma patients yearly or have 240 admissions with an Injury Severity Score of more than 15. (CD 2–4).	TYPE I
2	I, II, III	Through the trauma PIPS program and hospital policy, the trauma director must have responsibility and authority for determining each general surgeon's ability to participate on the trauma panel based on an annual review (CD 2–5).	TYPE II
2	I, II	Qualified attending surgeons must participate in major therapeutic decisions, be present in the emergency department for major resuscitations, be present at operative procedures, and be actively involved in the critical care of all seriously injured patients (CD 2–6).	TYPE I
2	I, II	A resident in postgraduate year 4 or 5 or an attending emergency physician who is part of the trauma team may be approved to begin resuscitation while awaiting the arrival of the attending surgeon but cannot independently fulfill the responsibilities of, or substitute for, the attending surgeon (CD 2–6).	TYPE I

2	I, II	The presence of such a resident or attending emergency physician may allow the attending surgeon to take call from outside the hospital. In this case, local criteria and a PIPS program must be established to define conditions requiring the attending surgeon's immediate hospital presence (CD 2–7).	TYPE II
2	I, II, III	For Level I, II and III trauma centers, it is expected that the surgeon will be in the emergency department on patient arrival, with adequate notification from the field. The maximum acceptable response time for the highest-level activation tracked from patient arrival for Level I and II trauma centers is 15 minutes, and 30 minutes for Level III trauma centers. The minimum criteria for full trauma team activation are provided in Table 2 in Chapter 5. The program must demonstrate that the surgeon's presence is in compliance at least 80 percent of the time (CD 2–8).	TYPE I
2	IV	For Level IV trauma centers, it is expected that the physician (if available) or midlevel provider will be in the emergency department on patient arrival, with adequate notification from the field. The maximum acceptable response time is 30 minutes for the highest level of activation, tracked from patient arrival. The PIPS program must demonstrate that the physician's (if available) or midlevel provider's presence is in compliance at least 80 percent of the time (CD 2–8).	TYPE I
2	I, II	The attending surgeon's immediate (within 15 minutes) arrival for patients with appropriate activation criteria must be monitored by the hospital's trauma PIPS program (CD 2–9).	TYPE I
2	I, II	The trauma surgeon on call must be dedicated to a single trauma center while on duty (CD 2–10)	TYPE II
2	I, II	In addition, a published backup call schedule for trauma surgery must be available (CD 2–11).	TYPE II
2	III	A Level III trauma center must have continuous general surgical coverage (CD 2–12).	TYPE II
2	III, IV	Well-defined transfer plans are essential (CD 2–13).	TYPE II
2	IV	Collaborative treatment and transfer guidelines reflecting the Level IV facilities' capabilities must be developed and regularly reviewed, with input from higher-level trauma centers in the region (CD 2–13).	TYPE II
2	IV	A Level IV facility must have 24-hour emergency coverage by a physician or midlevel provider (CD 2–14).	TYPE II
2	IV	The emergency department at Level IV centers must be continuously available for resuscitation with coverage by a registered nurse and physician or midlevel provider, and it must have a physician director (CD 2–15).	TYPE II
2	IV	These providers must maintain current Advanced Trauma Life Support® certification as part of their competencies in trauma (CD 2–16).	TYPE II
2	I, II, III, IV	For Level I, II, III and IV trauma centers a trauma medical director and trauma program manager knowledgeable and involved in trauma care must work together with guidance from the trauma peer review committee to identify events, develop corrective action plans, and ensure methods of monitoring, reevaluation, and benchmarking. (CD 2-17).	TYPE II

2	I, II, III, IV	Level I, II, III and IV trauma centers the multidisciplinary trauma peer review committee must meet regularly, with required attendance of medical staff active in trauma resuscitation, to review systemic and care provider issues, as well as propose improvements to the care of the injured (CD 2–18).	TYPE II
2	I, II, III, IV	Level I, II, III and IV trauma centers a PIPS program must have audit filters to review and improve pediatric and adult patient care (CD 2–19).	TYPE II
2	IV	Because of the greater need for collaboration with receiving trauma centers, the Level IV trauma center must also actively participate in regional and statewide trauma system meetings and committees that provide oversight (CD 2–20).	TYPE II
2	IV	The Level IV trauma center must also be the local trauma authority and assume the responsibility for providing training for prehospital and hospital-based providers (CD 2–21).	TYPE II
2	I, II, III, IV	Level I, II, III and IV trauma centers the facility must participate in regional disaster management plans and exercises (CD 2–22).	TYPE II
2	I, II, III	Any adult trauma center that annually admits 100 or more injured children younger than 15 years must fulfill the following additional criteria demonstrating their capability to care for injured children: trauma surgeons must be credentialed for pediatric trauma care by the hospital's credentialing body (CD 2–23).	TYPE II
2	I, II, III	There must be a pediatric emergency department area, a pediatric intensive care area, appropriate resuscitation equipment, and a pediatric-specific trauma PIPS program (CD 2–24).	TYPE II
2	I, II, III	For adult trauma centers annually admitting fewer than 100 injured children younger than 15 years, these resources are desirable. These hospitals, however, must review the care of their injured children through their PIPS program (CD 2–25).	TYPE II
Chapter 3: Prehospital Trauma Care			
3	I, II, III, IV	The trauma program must participate in the training of prehospital personnel, the development and improvement of prehospital care protocols, and performance improvement and patient safety programs (CD 3–1).	TYPE II
3	I, II, III, IV	The protocols that guide prehospital trauma care must be established by the trauma health care team, including surgeons, emergency physicians, medical directors for EMS agencies, and basic and advanced prehospital personnel (CD 3–2).	TYPE II
3	I, II, III	Rigorous multidisciplinary performance improvement is essential to evaluate overtriage and undertriage rates to attain the optimal goal of less than 5 percent undertriage (CD 3–3).	TYPE II
3	I, II, III	The trauma director must be involved in the development of the trauma center's bypass (diversion) protocol (CD 3–4).	TYPE II
3	I, II, III	The trauma surgeon must be involved in the decision regarding bypass (diversion) each time the center goes on bypass (CD 3–5).	TYPE II
3	I, II, III	The trauma center must not be on bypass (diversion) more than 5 percent of the time (CD 3–6).	TYPE II

3	I, II, III, IV	When a trauma center is required to go on bypass or to divert, the center must have a system to notify dispatch and EMS agencies (CD 3–7). The center must do the following: • Prearrange alternative destinations with transfer agreements in place • Notify other centers of divert or advisory status • Maintain a divert log • Subject all diverts and advisories to performance improvement procedures	TYPE II
Chapter 4: Interhospital Transfer			
4	i, II, III, IV	Direct physician-to-physician contact is essential (CD 4–1).	TYPE II
4	i, II, III	The decision to transfer an injured patient to a specialty care facility in an acute situation must be based solely on the needs of the patient and not on the requirements of the patient's specific provider network (for example, a health maintenance organization or a preferred provider organization) or the patient's ability to pay (CD 4–2).	TYPE II
4	i, Ii, III, IV	A very important aspect of interhospital transfer is an effective PIPS program that includes evaluating transport activities (CD 4–3).	TYPE II
4	I, II, Iii, IV	Perform a PIPS review of all transfers (CD 4–3).	TYPE ii
Chapter 5: Hospital Organization and the Trauma Program			
5	I, II, III, IV	A decision by a hospital to become a trauma center requires the commitment of the institutional governing body and the medical staff (CD 5–1).	TYPE I
5	I, II, III, IV	Documentation of administrative commitment is required from the governing body and the medical staff (CD 5–1)	TYPE I
5	I, II, III	This [administrative] support must be reaffirmed continually (every 3 years) and must be current at the time of verification (CD 5–2).	TYPE II
5	I, II, III	The [medical staff] support must be reaffirmed continually (every 3 years) and must be current at the time of verification (CD 5–3).	TYPE II
5	I, II, III	The trauma program must involve multiple disciplines and transcend normal departmental hierarchies (CD 5–4).	TYPE II
5	I, II, III	The TMD must be a current board-certified general surgeon (or a general surgeon eligible for certification by the American Board of Surgery according to current requirements) or a general surgeon who is an American College of Surgeons Fellow with a special interest in trauma care and must participate in trauma call (CD 5-5).	TYPE I
5	i, II, III	The TMD must be current in Advanced Trauma Life Support® (ATLS®) (CD 5–6).	TYPE II
5	I, II	The TMD must maintain an appropriate level of trauma-related extramural continuing medical education (16 hours annually, or 48 hours in 3 years) (CD 5–7)	TYPE II
5	I, II	Membership and active participation in regional or national trauma organizations are essential for the trauma director in Level I and II trauma centers and are desirable for TMDs in Level III and IV facilities (CD 5–8).	TYPE II

5	I, II, III	The TMD must have the authority to manage all aspects of trauma care (CD 5–9).	TYPE II
5	I, II, III	The TMD must chair and attend a minimum of 50% of the multidisciplinary trauma peer review committee meetings. (CD 5-10)	TYPE II
5	I, II, III	The TMD, In collaboration with the TPM, must have the authority to correct deficiencies In trauma care and exclude from trauma call the trauma team members who do not meet specified criteria (CD 5-11).	TYPE II
5	I, II, III	In addition, the TMD must perform an annual assessment of the trauma panel providers in the form of Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) when indicated by findings of the PIPS process (CD 5-11).	TYPE II
5	I, II, III	The TMD must have the responsibility and authority to ensure compliance with the above requirements and cannot direct more than one trauma center (CD 5-12).	TYPE II
5	I, II, III, IV	The criteria for a graded activation must be clearly defined by the trauma center, with the highest level of activation including the six required criteria listed in Table 2 (CD 5–13).	TYPE II
5	I, II	In Level I and II trauma centers, the highest level of activation requires the response of the full trauma team within 15 minutes of arrival of the patient, and the criteria should include physiologic criteria and some or several of the anatomic criteria (CD 5-14)	TYPE II
5	III, IV	In Level III and IV trauma centers the team must be fully assembled within 30 minutes (CD 5-15).	TYPE II
5	I, II, III, IV	Other potential criteria for trauma team activation that have been determined by the trauma program to be included in the various levels of trauma activation must be evaluated on an ongoing basis in the PIPS process (CD 5-16) to determine their positive predictive value in identifying patients who require the resources of the full trauma team.	TYPE II
5	I, II, III	The emergency physician may initially evaluate the limited-tier trauma patient, but the center must have a clearly defined response expectation for the trauma surgical evaluation of those patients requiring admission (CD 5-16).	TYPE II
5	I, II	In a Level I or II trauma center, seriously injured patients must be admitted to, or evaluated by, an identifiable surgical service staffed by credentialed trauma providers (CD 5-17).	TYPE II
5	III	In Level III centers, injured patients may be admitted to individual surgeons, but the structure of the program must allow the trauma director to have oversight authority for the care of these patients. (CD 5-17)	TYPE II
5	I, II, III	Programs that admit more than 10% of injured patients to non-surgical services must review all non-surgical admissions through the trauma PIPS process (CD 5–18).	TYPE II
5	I, II	Sufficient infrastructure and support to ensure adequate provision of care must be provided for this service (CD 5–19).	TYPE I

5	I, II	In teaching facilities, the requirements of the residency review committees must be met (CD 5–20).	TYPE II
5	III	There must be a method to identify the injured patients, monitor the provision of health care services, make periodic rounds, and hold formal and informal discussions with individual practitioners (CD 5–21).	TYPE I
5	I, II, III	In addition to administrative ability, the TPM must show evidence of educational preparation and clinical experience in the care of injured patients (CD 5-22).	TYPE II
5	I, II	In Level I and II trauma centers, the TPM must be full-time and dedicated to the trauma program (CD 5–23).	TYPE II
5	I, II	The TPM must show evidence of educational preparation, with a minimum of 16 hours (internal or external) of trauma-related continuing education per year and clinical experience in the care of injured patients (CD 5-24).	TYPE II
5	I, II, III	The trauma center's PIPS program must have a multidisciplinary trauma peer review committee chaired by the TMD (CD 5-25).	TYPE II
Chapter 6: Clinical Functions: General Surgery			
6	I, II, III	General surgeons caring for trauma patients must meet certain requirements, as described herein (CD–6-1). These requirements may be considered to be in four categories: current board certification, clinical involvement, performance improvement and patient safety, and education.	TYPE II
6	I, II, III	Board certification or eligible for certification by the American Board of Surgery according to current requirements or the alternate pathway is essential for general surgeons who take trauma call in Level I, II, and III trauma centers (CD 6–2).	TYPE II
6	I, II, III	Alternate Criteria (CD 6-3) for non–Board-Certified Surgeons in a Level I, II, or III Trauma Centers.	TYPE II
6	I, II, III	Trauma surgeons must have privileges in general surgery (CD 6–4).	TYPE II
6	I, II	In Level I and II trauma centers, the trauma surgeon on call must be dedicated to a single trauma center while on duty (CD 6–5).	TYPE I
6	I, II	In addition, a published backup call schedule for trauma surgery must be available (CD 6–6).	TYPE II
6	I, II, III, IV	For Level I and II trauma centers, the maximum acceptable response time is 15 minutes; for Level III and Level IV trauma centers, the maximum acceptable response time is 30 minutes. Response time will be tracked from patient arrival rather than from notification or activation. An 80 percent attendance threshold must be met for the highest-level activations (CD 2–8).	TYPE I
6	I, II, III	For Level I, II, and III trauma centers, the attending surgeon is expected to be present in the operating room for all operations. A mechanism for documenting this presence is essential (CD 6–7).	TYPE II

6	I, II, III	In Level I, II, and III trauma centers, there must be a multidisciplinary trauma peer review committee chaired by the trauma medical director (CD 5-25) and representatives from general surgery (CD 6-8), and liaisons from orthopedic surgery (CD 9-16), emergency medicine (CD 7-11), ICU (CD 11-62), and anesthesia (CD 11-13) – and for Level I and II trauma centers, neurosurgery (CD 8-13) and radiology (CD 11-39).	TYPE II
6	I, II, III	Each member of the group of general surgeons must attend at least 50 percent of the multidisciplinary trauma peer review committee meetings (CD 6–8).	TYPE II
6	I, II, III	All general surgeons on the trauma team must have successfully completed the Advanced Trauma Life Support® (ATLS®) course at least once (CD 6–9).	TYPE II
6	I, II	The trauma medical director must accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external trauma-related CME (CD 5–7).	TYPE II
6	I, II	In Level I and II trauma centers, this requirement must be met by the acquisition of 16 hours of CME per year on average or by demonstrating participation in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the performance improvement and patient safety program (CD 6–10).	TYPE II
Chapter 7: Clinical Functions: Emergency Medicine			
7	I, II, III	The emergency departments of Level I, II, and III trauma centers must have a designated emergency physician director supported by an appropriate number of additional physicians to ensure immediate care for injured patients (CD 7–1).	TYPE I
7	I, II	An emergency physician must be present in the department at all times in a Level I and Level II trauma centers (CD 7–2).	TYPE I
7	III	Occasionally, in a Level III trauma center, it is necessary for the physician to leave the emergency department for short periods to address in-house emergencies. Such cases and their frequency must be reviewed by the performance improvement and patient safety (PIPS) program to ensure that this practice does not adversely affect the care of patients in the emergency department (CD 7–3).	TYPE II
7	I, II, III	In institutions in which there are emergency medicine residency training programs, supervision must be provided by an in-house attending emergency physician 24 hours per day (CD 7–4).	TYPE II
7	I, II, III	These roles and responsibilities must be defined, agreed on, and approved by the director of the trauma service (CD 7–5).	TYPE II
7	I, II, III	Board certification or eligibility for certification by the appropriate emergency medicine board according to current requirements or the alternate pathway is essential for physicians staffing the emergency department and caring for trauma patients in Level I, II, and III trauma centers (CD 7–6).	TYPE II
7	I, II, III	Alternate Criteria (CD 6-3) for Non–Board-Certified Emergency Medicine Physicians in Level I, II, and III Trauma Centers	TYPE II
7	I, II, III	Emergency physicians on the call panel must be regularly involved in the care of injured patients (CD 7–7).	TYPE II

7	I, II, III	A representative from the emergency department must participate in the prehospital PIPS program (CD 7–8).	TYPE II
7	I, II, III	A designated emergency physician liaison must be available to the trauma director for PIPS issues that occur in the emergency department (CD 7–9).	TYPE II
7	I, II, III	Emergency physicians must participate actively in the overall trauma PIPS program and the multidisciplinary trauma peer review committee (CD 7–10).	TYPE II
7	I, II, III	The emergency medicine liaison on the multidisciplinary trauma peer review committee must attend a minimum of 50 percent of the committee meetings (CD 7–11).	TYPE II
7	I, II	In Level I and II trauma centers, the liaison from emergency medicine must accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external trauma-related CME (CD 7–12).	TYPE II
7	I, II	Other emergency physicians who participate on the trauma team also must be knowledgeable and current in the care of injured patients. This requirement may be met by documenting the acquisition of 16 hours of trauma-related CME per year on average or by demonstrating participation in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program (CD 7–13).	TYPE II
7	I, II, III	In Level I, II, and III trauma centers, all board-certified emergency physicians or those eligible for certification by an appropriate emergency medicine board according to current requirements must have successfully completed the ATLS course at least once (CD 7–14).	TYPE II
7	I, II, III	Physicians who are certified by boards other than emergency medicine who treat trauma patients in the emergency department are required to have current ATLS status (CD 7–15).	TYPE II
Chapter 8: Clinical Functions: Neurosurgery			
8	I, II	If this surgeon is not the director of the neurosurgery service, a neurologic surgeon liaison must be designated (CD 8–1).	TYPE I
8	I, II	Neurotrauma care must be continuously available for all TBI and spinal cord injury patients and must be present and respond within 30 minutes based on Institutional-specific criteria (CD 8–2).	TYPE I
8	I, II	The trauma center must provide a reliable, published neurotrauma call schedule with formally arranged contingency plans in case the capability of the neurosurgeon, hospital, or system to care for neurotrauma patients is overwhelmed (CD 8–3).	TYPE I
8	I, II	The center must have a predefined and thoroughly developed neurotrauma diversion plan that is implemented when the neurosurgeon on call becomes encumbered (CD 8–4). A predefined, thoroughly developed neurotrauma diversion plan must include the following: • Emergency medical services notification of neurosurgery advisory status/ diversion. • A thorough review of each instance by the performance improvement and patient safety (PIPS) program. • Monitoring of the efficacy of the process by the PIPS program.	TYPE II

8	I, II, III	A formal, published contingency plan must be in place for times in which a neurosurgeon is encumbered upon the arrival of a neurotrauma case (CD 8–5). The contingency plan must include the following: • A credentialing process to allow the trauma surgeon to provide initial evaluation and stabilization of the neurotrauma patient. • Transfer agreements with a similar or higher-level verified trauma center. • Direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support. • Monitoring of the efficacy of the process by the PIPS program.	TYPE II
8	I, II, III	If one neurosurgeon covers two centers within the same limited geographic area, there must be a published backup schedule (CD 8-6.)	TYPE II
8	I, II, III	In addition, the performance improvement process must demonstrate that appropriate and timely care is provided (CD 8–6).	TYPE II
8	III	A Level III trauma center must have a plan approved by the trauma medical director that determines which types of neurosurgical injuries may remain and which should be transferred (CD 8–7).	TYPE II
8	III	Transfer agreements must exist with appropriate Level I and Level II trauma centers (CD 8–8).	TYPE II
8	III	In all cases, whether patients are admitted or transferred, the care must be timely, appropriate, and monitored by the PIPS program (CD 8–9).	TYPE I
8	I, II, III	Board certification or eligibility for certification by an appropriate neurosurgical board according to the current requirements or the alternate pathway is essential for neurosurgeons who take trauma call in Level I, II, or III trauma centers (CD 8–10).	TYPE II
8	I, II, III	Alternate Criteria (CD 6-3) for Non–Board-Certified Neurosurgeons in Level I, II, and III Trauma Centers	TYPE II
8	I, II	Qualified neurosurgeons should be regularly involved in the care of patients with head and spinal cord injuries and must be credentialed by the hospital with general neurosurgical privileges (CD 8–11).	TYPE I
8	I, II	The neurosurgery service must participate actively in the overall trauma PIPS program (CD 8–12).	TYPE II
8	I, II	The neurosurgery liaison on the multidisciplinary trauma peer review committee must attend a minimum of 50 percent of the committee's meetings (CD 8–13).	TYPE II
8	III	Level III centers with any emergent neurosurgical cases must also have the participation of neurosurgery on the multidisciplinary trauma peer review committee (CD 8–13).	Type II
8	I, II	The liaison representative from neurosurgery must accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external trauma-related CME (CD 8–14)	TYPE II
8	I, II	This requirement may be documented by the acquisition of 16 hours of trauma CME per year on average or through an internal educational process (IEP)conducted by the trauma program and the neurosurgical liaison based on the principles of practice-based learning and the PIPS program (CD 8–15).	TYPE II

Chapter 9: Clinical Functions: Orthopaedic Surgery			
9	I, II	Because of their skills and training in the management of the acute and rehabilitation phases of musculoskeletal trauma, physical and occupational therapists and rehabilitation specialists are essential at Level I and II trauma centers (CD 9–1).	TYPE II
9	I, II, III	Operating rooms must be promptly available to allow for emergency operations on musculoskeletal injuries, such as open fracture debridement and stabilization, external fixator placement, and compartment decompression (CD 9–2).	TYPE I
9	I, II	In Level I and II trauma centers, a system must be organized so that musculoskeletal trauma cases can be scheduled without undue delay and not at inappropriate hours that might conflict with more urgent surgery or other elective procedures (CD 9–3).	TYPE II
9	I, II, III	Level I, II, and III trauma centers must have an orthopaedic surgeon who is identified as the liaison to the trauma program (CD 9–4).	TYPE I
9	I	In a Level I trauma center the orthopaedic care must be overseen by an individual who has completed a fellowship in orthopaedic traumatology approved by the Orthopaedic Trauma Association (OTA) (CD 9-5).	TYPE I
9	PTC I	In Pediatric Level I trauma centers this requirement may be met by having formal transfer agreements that specify which cases will be transferred for high level orthopaedic oversight and assuring that all such transfers (or potential transfers) are reviewed as part of the performance improvement process (CD 9-5).	TYPE I
9	I, II	Orthopaedic team members must have dedicated call at their institution or have an effective backup call system (CD 9–6).	TYPE II
9	I, II	They must be available in the trauma resuscitation area within 30 minutes after consultation has been requested by the surgical trauma team leader for multiply injured patients (CD 9-7) based on institution-specific criteria.	TYPE II
9	I, II	The performance improvement process must ensure that care is timely and appropriate (CD 9-8).	TYPE II
9	I, II	If the on-call orthopaedic surgeon is unable to respond promptly, a backup consultant on-call surgeon must be available (CD 9-9).	TYPE II
9	I, II	The design of this system is the responsibility of the orthopaedic trauma liaison but must be approved by the trauma program director (CD 9-10).	TYPE II
9	I, II	The trauma center must provide all the necessary resources for modern musculoskeletal trauma care, including instruments, equipment, and personnel, along with readily available operating rooms for musculoskeletal trauma procedures (CD 2–3).	TYPE II
9	III	Level III facilities vary significantly in the staff and resources that they can commit to musculoskeletal trauma care, but they must have an orthopaedic surgeon on call and promptly available 24 hours a day (CD 9-11).	TYPE II

9	III	If the orthopaedic surgeon is not dedicated to a single facility while on call, then a published backup schedule is required (CD 9-12).	TYPE II
9	III	The PIPS process must review the appropriateness of the decision to transfer or retain major orthopaedic trauma cases (CD 9-13).	TYPE II
9	I, II	There must be protocols in Level I and II centers for the following orthopaedic emergencies: 1) the type and severity of pelvic and acetabular fractures that will be treated at the institutions as well as those that will be transferred out for care; 2) the timing and sequence for the treatment of long bone fractures In multiply injured patients; and 3) the wash out time for open fractures. These protocols must be included as part of the PIPS process (CD 9-14).	TYPE II
9	I, II, III	The orthopaedic service must participate actively with the overall trauma PIPS program and the multidisciplinary trauma peer review committee (CD 9–15).	TYPE II
9	I, II, III	The orthopaedic liaison to the trauma PIPS program must attend a minimum of 50 percent of the multidisciplinary trauma peer review committee meetings (CD 9–16).	TYPE II
9	I, II, III	Board certification or eligibility for certification by an appropriate orthopaedic board according to the current requirements, or the alternate pathway is essential for orthopaedic surgeons who take trauma call in Level I, II, and III trauma centers (CD 9–17).	TYPE II
9	I, II, III	Alternate Criteria (CD 6-3) for Non–Board-Certified Orthopaedic Surgeons in a Level I, II, or III Trauma Center	TYPE II
9	I, II	The orthopaedic surgical liaison to the trauma program at Level I and II centers must accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external trauma-related continuing medical education (CME) (CD 9–18).	TYPE II
9	I, II	This requirement may be documented by the acquisition of 16 hours of trauma CME per year on average or through an internal educational process conducted by the trauma program and the orthopaedic liaison based on the principles of practice-based learning and the PIPS program (CD 9–19).	TYPE II
Chapter 10: Pediatric Trauma Care			
10	PTC I, II	Hospitals that pursue verification as pediatric trauma centers must meet the same resource requirements as adult trauma centers, in addition to pediatric resource requirements (CD 2–3) (Table 1)	TYPE II
10	PTC I	A Level I pediatric trauma center must annually admit 200 or more injured children younger than 15 years (CD 10–1)	TYPE I
10	PTC II	A Level II pediatric trauma center must annually admit 100 or more injured children younger than 15 years (CD 10–2).	TYPE I
10	PTC I, II	All Level I and II pediatric trauma centers must have a dedicated pediatric trauma program manager (CD 10–3)	TYPE I
10	PTC I, II	All Level I and II pediatric trauma centers must have a pediatric trauma registrar (CD 10–4).	TYPE II
10	PTC I	In a Level I pediatric trauma center, the pediatric trauma program manager must be a full-time position dedicated to the pediatric trauma service (CD 10–5)	TYPE II

10	PTC I, II	All pediatric trauma centers must have a pediatric trauma performance improvement and patient safety (PIPS) program (CD 10–6).	TYPE I
10	PTC I, II	In addition, all pediatric trauma centers must have the following programs: pediatric rehabilitation, child life and family support programs, pediatric social work, child protective services, pediatric injury prevention, community outreach, and education of health professionals and the general public in the care of pediatric trauma patients (CD 10–7).	TYPE II
10	PTC I, II	Level I and II pediatric trauma centers must have a mechanism in place to assess children for maltreatment (CD 10–8).	TYPE II
10	PTC I	Level I pediatric trauma centers must have identifiable pediatric trauma research (CD 10–9).	TYPE II
10	PTC I	The pediatric Level I center's research requirement is equivalent to that of adult Level I trauma centers (CD 10–10).	TYPE II
10	PTC I	In combined Level I adult and pediatric centers, half of the research requirement must be pediatric research (CD 10–11).	TYPE II
10	PTC I	A Level I pediatric trauma center must have at least two surgeons who are board certified or eligible for certification by the American Board of Surgery according to current requirements in pediatric surgery (CD 10–12).	TYPE I
10	PTC I	On staff, there must be one board-certified surgeon or one surgeon eligible for certification by an appropriate orthopaedic board (see Chapter 9, Clinical Functions: Orthopaedic Surgery) according to the current requirements of that board who also has had pediatric fellowship training (CD 10–13).	TYPE I
10	PTC I	Additionally, there must be on staff at least one board-certified surgeon or one surgeon eligible for certification by an appropriate neurosurgical board (see Chapter 8, Clinical Functions: Neurosurgery) according to current requirements of that board who also has had pediatric fellowship training (CD 10–14).	TYPE I
10	PTC I	There must be one additional board-certified orthopaedic surgeon or surgeon eligible for certification by an appropriate orthopaedic board according to the current requirements of that board (CD 10–15), who is identified with demonstrated interests and skills in pediatric trauma care.	TYPE II
10	PTC I	There must be one additional board-certified neurosurgeon or surgeon eligible for certification by an appropriate neurosurgical board according to the current requirements of that board, who is identified with demonstrated interests and skills in pediatric trauma care (CD 10–16).	TYPE II
10	PTC I	There must be two physicians who are board certified or eligible for certification in pediatric critical care medicine, according to current requirements in pediatric critical care medicine: or in pediatric surgery and surgical critical care by the American Board of Surgery (CD 10–17).	TYPE I
10	PTC I	There must be two physicians who are board certified or eligible for certification by an appropriate emergency medicine board according to current requirements in pediatric emergency medicine (CD 10–18).	TYPE II

10	PTC I, II	The pediatric intensive care unit must be staffed by individuals credentialed by the hospital to provide pediatric trauma care in their respective areas (CD 10–19).	TYPE II
	PTC I, II	The pediatric section of the emergency department must be staffed by individuals credentialed by the hospital to provide pediatric trauma care in their respective areas (CD 10-20).	TYPE II
10	PTC II	In a Level II pediatric trauma center, there must be at least one pediatric surgeon who is board-certified or eligible for certification by the American Board of Surgery according to current requirements in pediatric surgeon (CD 10–21).	TYPE I
10	PTC II	There must be one surgeon who is board-certified or eligible for certification by an appropriate orthopaedic board (CD 10–22) identified with demonstrated interests and skills in pediatric trauma care.	TYPE II
10	PTC II	There must be one surgeon who is board-certified or eligible for certification by an appropriate neurosurgical board (CD 10–23) identified with demonstrated interests and skills in pediatric trauma care.	TYPE I
10	PTC I	In a Level I pediatric trauma center, the pediatric trauma medical director must be board certified or eligible for certification by the American Board of Surgery according to current requirements for pediatric surgery or alternatively, a pediatric surgeon who is a Fellow of the American College of Surgeons with a special interest in pediatric trauma care, and must participate in trauma call (CD 10–24).	TYPE I
10	PTC II	In a Level II pediatric trauma center, the pediatric trauma medical director should be a board-certified pediatric surgeon or a surgeon eligible for certification by the American Board of Surgery according to current requirements for pediatric surgeons. This individual must be a board-certified general surgeon or a general surgeon eligible for certification by the American Board of Surgery according to current requirements qualified to serve on the pediatric trauma team as defined in the following paragraph (CD 10–25).	TYPE I
10	PTC I, II	When the number of pediatric surgeons on staff is too few to sustain the pediatric trauma panel, general surgeons who are board certified or eligible for certification by the American Board of Surgery according to current requirements may serve on the pediatric trauma team. In this circumstance, they must be credentialed by the hospital to provide pediatric trauma care, be members of the adult trauma panel, and be approved by the pediatric trauma medical director (CD 10–26).	TYPE I
10	PTC I	At a minimum, a Level I pediatric trauma center must have continuous rotations in trauma surgery for senior residents (Clinical PGY 3–5) who are part of an Accreditation Council for Graduate Medical Education–accredited program (CD 10–27).	TYPE I
10	PTC I	At a minimum, these rotations should include residency programs in all the following specialties: general surgery, orthopaedic surgery, emergency medicine, and neurosurgery. They may also include support of a pediatric surgical fellowship (CD 10–28).	TYPE I

10	PTC I, II	In Level I and II pediatric trauma centers, other specialists (in anesthesiology, neurosurgery, orthopaedic surgery, emergency medicine, radiology, and rehabilitation) providing care to injured children who are not pediatric-trained providers also should have sufficient training and experience in pediatric trauma care and be knowledgeable about current management of pediatric trauma in their specialty. The program must make specialty-specific pediatric education available for these specialists (CD 10–29).	TYPE II
10	PTC I, II	An organized pediatric trauma service led by a pediatric trauma medical director must be present in Level I and II pediatric trauma centers (CD 10–30).	TYPE I
10	PTC I, II	The pediatric trauma service must maintain oversight of the patient's management while the patient is in the intensive care unit (CD 10–31).	TYPE II
10	PTC I, II	The trauma service should work collaboratively with the pediatric critical care providers, although all significant therapeutic decisions must be approved by the trauma service, and the service must be made aware of all significant clinical changes (CD 10–32).	TYPE II
10	PTC I, II	The surgical director of the pediatric intensive care unit must participate actively in the administration of the unit, as evidenced by the development of pathways and protocols for care of surgical patients in the intensive care unit and in unit-based performance improvement and should be board-certified in surgical critical care (CD 10–33).	TYPE I
10	PTC I, II	Pediatric surgeons or trauma surgeons with pediatric privileges must be included in all aspects of the care of injured children admitted to an intensive care unit (CD 10–34).	TYPE II
10	ATCTIC I, II	Any adult trauma center that annually admits 100 or more injured children younger than 15 years must fulfill the following additional criteria demonstrating its capability to care for the injured child (CD 2-23).	TYPE II
10	ATCTIC I, II	The trauma surgeons must be credentialed for pediatric trauma care by the hospital's credentialing body (CD 2-23).	TYPE II
10	ATCTIC I, II	There must be a pediatric emergency department area, a pediatric intensive care area, appropriate resuscitation equipment, and a pediatric-specific trauma PIPS program (CD 2-24).	TYPE II
10	ATCTIC I, II	For adult trauma centers admitting fewer than 100 injured children younger than 15 years per year, these resources are desirable. These hospitals, however, must review the care of all injured children through their PIPS programs (CD 2-25).	TYPE II
10	PTC I, II	Level I and II pediatric trauma centers must submit data to the National Trauma Data Bank® (NTDB®) (CD 10–35).	TYPE II
10	PTC I, II	There must be a trauma peer review committee chaired by the pediatric trauma medical director with participation by the pediatric /general surgeons and liaisons from pediatric/general surgery, orthopaedic surgery, neurosurgery, emergency medicine, pediatric critical care medicine, anesthesia, and radiology to improve trauma care by reviewing selected deaths, complications, and sentinel events with the objectives of identification of issues and appropriate responses (CD 10–36).	TYPE I

10	PTC I, II	The aforementioned representatives must attend at least 50% of the trauma peer review meetings, and their attendance must be documented (CD 10–37)	TYPE II
10	PTC I, II	All pediatric and general surgeons on the pediatric trauma panel treating children must attend at least 50% of the trauma peer review meetings (CD 10–38).	TYPE II
10	PTC I, II	In Level I and II pediatric trauma centers, the pediatric trauma medical director and the liaisons from neurosurgery, orthopaedic surgery, emergency medicine, and critical care medicine must each accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external CME, of which at least 12 hours (in 3 years) must be related to clinical pediatric trauma care (CD 10–39)	TYPE II
10	PTC I, II	The other general surgeons, orthopaedic surgeons, neurosurgeons, emergency medicine physicians, and critical medicine care physicians who take trauma call in Level I and II pediatric trauma centers also must be knowledgeable and current in the care of injured patients. This requirement may be met by documenting the acquisition of 16 hours of CME per year on average or by demonstrating participation in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program (CD 10–40).	TYPE II
Chapter 11 Collaborative Clinical Services			
11	I, II, III	Anesthesiology services are critical in the management of severely injured patients and must be available within 30 minutes for emergency operations (CD 11–1)	TYPE I
11	I, II, III	Anesthesiology services are critical in the management of severely injured patients and must be available within 30 minutes for managing airway problems (CD 11–2).	TYPE I
11	I, II	The anesthetic care of injured patients in a Level I or II trauma center must be organized and supervised by an anesthesiologist who is highly experienced and committed to the care of injured patients and who serves as the designated liaison to the trauma program (CD 11–3).	TYPE I
11	I, II, III	In Level I, II, and III trauma centers, a qualified and dedicated physician anesthesiologist must be designated as the liaison to the trauma program (CD 11–3),	TYPE I
11	I, II	Anesthesia services in Level I and II trauma centers must be available in-house 24 hours a day (CD 11–4).	TYPE I
11	I, II	When anesthesiology senior residents or CRNAs are used to fulfill availability requirements, the attending anesthesiologist on call must be advised, available within 30 minutes at all times, and present for all operations (CD 11–5).	TYPE I
11	I, II, III	The availability of anesthesia services and delays in airway control or operations must be documented by the hospital performance improvement and patient safety (PIPS) process (CD 11–6).	TYPE II
11	III	In Level III hospitals, in-house anesthesia services are not required, but anesthesiologists or CRNAs must be available within 30 minutes (CD 11–7).	TYPE I

11	III	In Level III trauma centers without in-house anesthesia services, protocols must be in place to ensure the timely arrival at the bedside by the anesthesia provider within 30 minutes of notification and request. (CD 11–8).	TYPE I
11	III	Under these circumstances, the presence of a physidan skilled in emergency airway management must be documented (CD 11–9).	TYPE I
11	I, II	All anesthesiologists taking call must have successfully completed an anesthesia residency program (CD 11–10).	TYPE I
11	I, II	Furthermore, in Level I and II trauma centers, anesthesiologists taking call must be currently board certified or eligible for certification by an appropriate anesthesia board according to current requirements in anesthesiology (CD 11–11).	TYPE I
11	I, II	Board certification or eligibility for certification is essential for anesthesiologists who take trauma call in Level I and II trauma centers (CD 11–11).	TYPE I
11	I, II, III	In Level I, II, and III trauma centers participation in the trauma PIPS program by the anesthesia liaison is essential (CD 11–12).	TYPE II
11	I, II, III	The anesthesiology liaison to the trauma program must attend at least 50 percent of the multidisciplinary peer review meetings, with documentation by the trauma PIPS program (see Chapter 16, Performance Improvement and Patient Safety) (CD 11–13).	TYPE II
11	I, II	An operating room must be adequately staffed and available within 15 minutes at Level I and II trauma centers (CD 11–14).	TYPE I
11	I, II	In Level I and II trauma centers, if the first operating room is occupied, an adequately staffed additional room must be available (CD 11–15).	TYPE II
11	I, II	Availability of the operating room personnel and timeliness of starting operations must be continuously evaluated by the trauma PIPS process and measures must be implemented to ensure optimal care (CD 11–16).	TYPE II
11	III	In Level III trauma centers, an operating room must be adequately staffed and available within 30 minutes (CD 11–17).	TYPE I
11	III	If an on-call team is used, the availability of operating room personnel and the timeliness of starting operations must be continuously evaluated by the trauma PIPS process, and measures must be implemented to ensure optimal care (CD 11–18).	TYPE II
11	I, II, III	All trauma centers must have rapid fluid infusers, thermal control equipment for patients and resuscitation fluids, intraoperative radiologic capabilities, equipment for fracture fixation, and equipment for bronchoscopy and gastrointestinal endoscopy (CD 11–19).	TYPE I
11	I, II, III	Level I, II, III trauma centers must have the necessary equipment to perform a craniotomy (CD 11–20). Only Level III trauma centers that do not offer neurosurgery services are not required to have craniotomy equipment.	TYPE I
11	I	Level I trauma centers must have cardiothoracic surgery capabilities available 24 hours per day and should have cardiopulmonary bypass equipment (CD 11–21)	TYPE II

11	I, II	In Level I and Level II trauma centers, if cardiopulmonary bypass equipment is not immediately available, a contingency plan, including immediate transfer to an appropriate center and 100 percent performance improvement review of all patients transferred, must be in place (CD 11–22).	TYPE II
11	I	Level I trauma centers must have an operating microscope available 24 hours per day (CD 11–23).	TYPE II
11	I, II, III	At Level I, II, and III trauma centers, a PACU with qualified nurses must be available 24 hours per day to provide care for the patient if needed during the recovery phase (CD 11–24).	TYPE I
11	I, II, III	If this availability requirement is met with a team on call from outside the hospital, the availability of the PACU nurses and compliance with this requirement must be documented by the PIPS program (CD 11–25).	TYPE II
11	I, II, III	The PACU must have the necessary equipment to monitor and resuscitate patients, consistent with the process of care designated by the institution (CD 11–26).	TYPE I
11	I, II, III	The PIPS program, at a minimum, must address the need for pulse oximetry, end-tidal carbon dioxide detection, arterial pressure monitoring, pulmonary artery catheterization, patient rewarming, and intracranial pressure monitoring (CD 11–27).	TYPE II
11	I, II, III	The trauma center must have policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to, and while in, the radiology department (CD 11–28).	TYPE II
11	I, II, III, IV	Conventional radiography must be available in all trauma centers 24 hours per day (CD 11–29).	TYPE I
11	I, II, III	Computed tomography (CT) must be available in Levels I, II, and III trauma centers 24 hours per day (CD 11–30)	TYPE I
11	I, II	An in-house radiology technologist and CT technologist are required at Level I and II trauma centers (CD 11–31).	TYPE I
11	I, II, III	In Level I, II, and III trauma centers, qualified radiologists must be available within 30 minutes in person or by teleradiology for the interpretation of radiographs. (CD 11-32)	TYPE I
11	I, II	In Level I and II trauma centers qualified radiologists must be available within 30 minutes to perform complex imaging studies, or interventional procedures (CD 11-33).	TYPE II
11	I, II, III	In Level I, II, and III trauma centers diagnostic information must be communicated in a written or electronic form and in a timely manner (CD 11–34).	TYPE II
11	I, II, III	Critical information deemed to immediately affect patient care must be verbally communicated to the trauma team in a timely manner (CD 11–35).	TYPE II
11	I, II, III	The final report must accurately reflect the chronology and content of communications with the trauma team, including changes between the preliminary and final interpretations (CD 11–36).	TYPE II

11	I, II, III	Changes in interpretation between preliminary and final reports, as well as missed injuries, must be monitored through the PIPS program (CD 11–37).	TYPE II
11	I, II	In Level I and II facilities, a radiologist must be appointed as liaison to the trauma program (CD 11–38).	TYPE II
11	I, II	The radiologist liaison must attend at least 50 percent of peer review meetings and should educate and guide the entire trauma team in the appropriate use of radiologic services (CD 11–39).	TYPE II
11	I, II	In Level I and II trauma centers, participation in the trauma PIPS program process by the radiology liaison is essential (CD 11–40).	TYPE II
11	I, II	At a minimum, radiologists must be involved in protocol development and trend analysis that relate to diagnostic imaging (CD 11–41).	TYPE II
11	I, II	Level I and II facilities must have a mechanism in place to view radiographic imaging from referring hospitals within their catchment area (CD 11–42).	TYPE II
11	I, II	Board certification or eligibility for certification by an appropriate radiology board according to current requirements is essential for radiologists who take trauma call in Level I and II trauma centers (CD 11–43).	TYPE II
11	I, II	Interventional radiologic procedures and sonography must be available 24 hours per day at Level I and II trauma centers (CD 11–44).	TYPE I
11	I, II	Magnetic resonance imaging (MRI) capability must be available 24 hours per day at Level I and II trauma centers (CD 11–45).	TYPE II
11	I, II	The MRI technologist may respond from outside the hospital; however, the PIPS program must document and review arrival within 1 hour of being called. This time should meet current clinical guidelines (CD 11–46).	TYPE II
11	III	In Level III centers, if the CT technologist takes call from outside the hospital, the PIPS program must document the technologist's time of arrival at the hospital (CD 11–47).	TYPE II
11	I	In a Level I trauma center, a surgically directed ICU physician team must be led by a surgeon boarded in surgical critical care, and critically ill trauma patients should be cared for in a designated ICU (CD 11–48).	TYPE I
11	I	A surgeon with current board certification in surgical critical care must be designated as the ICU director (CD 11–49).	TYPE II
11	I	The ICU team may be staffed by critical care physicians from different specialties but must remain surgically directed as noted above (CD 11-49).	TYPE II
11	I	The ICU must be staffed with a dedicated ICU physician team led by the ICU director (CD 11–50).	TYPE II
11	I	Appropriately trained physicians must be available in-house within 15 minutes to provide care for the ICU patients 24 hours per day (CD 11–51).	TYPE I
11	I	If the trauma attending provides coverage, a backup ICU attending must be identified and readily available (CD 11–52).	TYPE II

11	II, III	In Level II and III trauma centers, a surgeon must serve as co-director or director of the ICU and be actively involved in, and responsible for, setting policies and administrative decisions related to trauma ICU patients (CD 11–53).	TYPE II
11	II, III	In a Level II facility, the ICU director or co-director should be currently board certified or eligibility for certification in surgical critical care. In Level II and III facilities, the ICU director or co-director must be a surgeon who is currently board certified or eligible for certification by the current standard requirements (CD 11–54).	TYPE II
11	II	In Level II trauma centers, physician coverage of critically ill trauma patients must be available within 15 minutes 24 hours per day for interventions by a credentialed provider (CD 11–55).	TYPE I
11	III	In Level III trauma centers, physician coverage of the ICU must be available within 30 minutes, with a formal plan in place for emergency coverage (CD 11–56).	TYPE I
11	III	In Level III trauma centers, the PIPS program must review all ICU admissions and transfers of ICU patients to ensure that appropriate patients are being selected to remain at the Level III center vs. being transferred to a higher level of care (CD 11–57).	TYPE II
11	I, II, III	In Level I, II, and III trauma centers, the trauma surgeon must retain responsibility for the patient and coordinate all therapeutic decisions (CD 11–58).	TYPE I
11	I, II, III	Many of the daily care requirements can be collaboratively managed by a dedicated ICU team, but the trauma surgeon must be kept informed and concur with major therapeutic and management decisions made by the ICU team (CD 11–59).	TYPE I
11	I, II, III, IV	For all levels of trauma centers, the PIPS program must document that timely and appropriate ICU care and coverage are being provided (CD 11–60).	TYPE II
11	I, II, III	In all Level I, II, and III trauma centers, the timely response of credentialed providers to the ICU must be continuously monitored as part of the PIPS program (CD-11-60).	TYPE II
11	I, II, III	There must be a designated ICU liaison to the trauma service (CD 11–61).	TYPE II
11	I, II, III	This [ICU] liaison must attend at least 50 percent of the multidisciplinary peer review meetings, with documentation by the trauma PIPS program (CD 11–62).	TYPE II
11	I, II	The ICU liaison to the trauma program at Level I and II centers must accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external trauma-related continuing medical education (CME) (CD 11–63).	TYPE II
11	I, II	This requirement must be documented by the acquisition of 16 hours of trauma CME per year, on average, or through an internal educational process conducted by the trauma program and the ICU liaison based on the principles of practice-based learning and the PIPS program (CD 11–64).	TYPE II
11	I, II, III	At Level I, II, and III trauma centers, qualified critical care nurses must be available 24 hours per day to provide care for patients during the ICU phase (CD 11–65).	TYPE I

11	I, II, III	The patient-to-nurse ratio in the ICU must not exceed two to one (CD 11–66).	TYPE II
11	i, II, III	The ICU must have the necessary equipment to monitor and resuscitate patients (CD 11–67).	TYPE I
11	I, II, III	Intracranial pressure monitoring equipment must be available in Level I and II trauma centers and in Level III trauma centers with neurosurgical coverage that admit neurotrauma patients (CD 11–68).	TYPE I
11	III	Trauma patients must not be admitted or transferred by a primary care physician without the knowledge and consent of the trauma service, and the PIPS program should monitor adherence to this guideline (CD 11–69).	TYPE II
11	I	Level I facilities are prepared to manage the most complex trauma patients and must have available a full spectrum of surgical specialists, including specialists in orthopaedic surgery, neurosurgery, cardiac surgery, thoracic surgery, vascular surgery, hand surgery, microvascular surgery, plastic surgery, obstetric and gynecologic surgery, ophthalmology, otolaryngology, and urology (CD 11–70).	TYPE I
11	II	Level II centers must have the surgical specialists described for Level I trauma centers and should provide cardiac surgery (CD 11–71). [Level I facilities must have specialists in orthopaedic surgery, neurosurgery, thoracic surgery, vascular surgery, hand surgery, microvascular surgery, plastic surgery, obstetric and gynecologic surgery, ophthalmology, otolaryngology, and urology.	TYPE I
11	III	Level III trauma centers must have the availability and commitment of orthopaedic surgeons (CD 11–72).	TYPE I
11	I, Ii, III	For all patients being transferred for specialty care, such as burn care, microvascular surgery, cardiopulmonary bypass capability, complex ophthalmologic surgery, or high-complexity pelvic fractures, agreements with a similar or higher-qualified verified trauma center should be in place. If this approach is used, a clear plan for expeditious critical care transport, follow-up, and performance monitoring is required (CD 8–5). If complex cases are being transferred out, a contingency plan should be in place and must include the following: • A credentialing process to allow the trauma surgeon to provide initial evaluation and stabilization of the patient. • Transfer agreements with similar or higher-verified trauma centers. • Direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support. • Monitoring of the efficacy of the process by the PIPS programs.	TYPE II
11	I, II	In Level I and II trauma centers, medical specialists on staff must include specialists in cardiology, internal medicine, gastroenterology, infectious disease, pulmonary medicine, and nephrology and their respective support teams (for example, respiratory therapy, a dialysis team, and nutrition support) (CD 11–73).	TYPE II
11	III	In a Level III facility, internal medicine specialists must be available on the medical staff (CD 11–74).	TYPE II
11	I, II	Several support services are required to care for trauma patients. In Level I and II trauma centers, a respiratory therapist must be available in the hospital 24 hours per day (CD 11–75).	TYPE I

11	III	In Level III centers, there must be a respiratory therapist on call 24 hours per day (CD 11–76).	TYPE I
11	I, II	Acute hemodialysis must be available in Level I and II trauma centers (CD 11–77).	TYPE II
11	III	Level III trauma centers that do not have dialysis capabilities must have a transfer agreement in place (CD 11–78).	TYPE II
11	I, II	Nutrition support services must be available in Level I and II centers (CD 11–79).	TYPE II
11	I, II, III, IV	In trauma centers of all levels, laboratory services must be available 24 hours per day for the standard analyses of blood, urine, and other body fluids, including microsampling when appropriate (CD 11–80).	TYPE I
11	I, II, III, IV	The blood bank must be capable of blood typing and cross-matching (CD 11–81).	TYPE I
11	I, II	For Level I and II centers, the blood bank must have an adequate in-house supply of red blood cells, fresh frozen plasma, platelets, cryoprecipitate, and appropriate coagulation factors to meet the needs of injured patients (CD 11–82).	TYPE I
11	III	In Level III centers, the blood bank must have an adequate supply of packed red blood cells and fresh frozen plasma available within 15 minutes (CD 11–83).	TYPE I
11	I, II, III, IV	Trauma centers of all levels must have a massive transfusion protocol developed collaboratively between the trauma service and the blood bank (CD 11–84).	TYPE I
11	I, II, III	Coagulation studies, blood gas analysis, and microbiology studies must be available 24 hours per day (CD 11–85).	TYPE I
11	I, II, III, IV	Advanced practitioners who participate in the initial evaluation of trauma patients must demonstrate current verification as an Advanced Trauma Life Support® provider (CD 11–86).	TYPE II
11	I, II, III, IV	The trauma program must also demonstrate appropriate orientation, credentialing processes, and skill maintenance for advanced practitioners, as witnessed by an annual review by the trauma medical director (CD 11–87).	TYPE II
Chapter 12: Rehabilitation			
12	I, II	In Level I and II trauma centers, rehabilitation services must be available within the hospital's physical facilities or as a freestanding rehabilitation hospital, in which case the hospital must have transfer agreements (CD 12–1).	TYPE II
12	I, II	Rehabilitation consultation services, occupational therapy, speech therapy, physical therapy, and social services are often needed in the critical care phase and must be available in Level I and II trauma centers (CD 12–2).	TYPE II
12	I, II, III	Physical therapy (CD 12–3) must be provided in Level I, II, and III trauma centers.	TYPE I
12	I, II, III	Social services (CD 12–4) must be provided in Level I, II, and III trauma centers.	TYPE II
12	I, II	Occupational therapy (CD 12–5) must be provided in Level I and II centers.	TYPE II

12	I, II	Speech therapy (CD 12–6) must be provided in Level I and II centers.	TYPE II
12	I, II	In Level I and II trauma centers, these services [physical therapy, social services, occupational therapy and speech therapy] must be available during the acute phase of care, including intensive care (CD 12–7).	TYPE II
Chapter 13: Rural Trauma Care			
13	I, II, III, IV	Direct contact of the physician or midlevel provider with a physician at the receiving hospital is essential (CD 4–1).	TYPE II
13	III, IV	Transfer guidelines and agreements between facilities are crucial and must be developed after evaluating the capabilities of rural hospitals and medical transport agencies (CD 2–13).	TYPE II
13	I, II, III, IV	All transfers must be evaluated as part of the receiving trauma center's performance improvement and patient safety (PIPS) process (CD 4–3), and feedback should be provided to the transferring center.	TYPE II
13	I, II	Level I and II centers must be able to read images from referring centers (CD 11–41)	TYPE II
13	I, II, III, IV	The foundation for evaluation of a trauma system is the establishment and maintenance of a trauma registry (CD 15–1).	TYPE II
13	I, II, III, IV	Issues that must be reviewed will revolve predominately around (1) system and process issues such as documentation and communication; (2) clinical care, including identification and treatment of immediate life- threatening injuries (ATLS®); and (3) transfer decisions (CD 16-10).	TYPE II
13	I, II, III, IV	The best possible care for patients must be achieved with a cooperative and inclusive program that clearly defines the role of each facility within the system (CD 1–1).	TYPE II
Chapter 14: Guidelines for the Operation of Burn Centers			
14	I, II, III, IV	Trauma centers that refer burn patients to a designated burn center must have in place written transfer agreements with the referral burn center (CD 14–1)	TYPE II
Chapter 15: Trauma Registry			
15	I, II, III, IV	Trauma registry data must be collected and analyzed by every trauma center (CD 15–1).	TYPE II
15	I, II, III	Finally, these data must be collected in compliance with the National Trauma Data Standard (NTDS) and submitted to the National Trauma Data Bank® (NTDB®) every year in a timely fashion so that they can be aggregated and analyzed at the national level (CD 15–2).	TYPE II
15	I, II, III, IV	The trauma registry is essential to the performance Improvement and patient safety (PIPS) program and must be used to support the PIPS process (CD 15–3).	TYPE II
15	I, II, III, IV	Furthermore, these findings must be used to identify injury prevention priorities that are appropriate for local Implementation (CD 15–4).	TYPE II
15	I, II, III	All trauma centers must use a risk adjusted benchmarking system to measure performance and outcomes (CD 15-5).	TYPE II
15	I, II, III, IV	Trauma registries should be concurrent. At a minimum, 80 percent of cases must be entered within 60 days of discharge (CD 15–6)	TYPE II

15	I, II, III	[Registrar] They must attend or have previously attended two courses within 12 months of being hired: (1) the American Trauma Society's Trauma Registrar Course or equivalent provided by a state trauma program; and (2) the Association of the Advancement of Automotive Medicine's Injury Scaling Course (CD 15–7).	TYPE II
15	I, II, III, IV	The trauma program must ensure that appropriate measures are in place to meet the confidentiality requirements of the data (CD 15–8).	TYPE II
15	I, II, III	One full-time equivalent employee dedicated to the registry must be available to process the data capturing the NTDS data set for each 500–750 admitted patients annually (CD 15–9).	TYPE II
15	I, II, III, IV	Strategies for monitoring data validity are essential (CD 15–10).	TYPE II
Chapter 16: Performance Improvement and Patient Safety			
16	I, II, III	Trauma centers must have a PIPS program that includes a comprehensive written plan outlining the configuration and identifying both adequate personnel to implement that plan and an operational data management system (CD 16–1).	TYPE II
16	I, II, III, IV	The PIPS program must be supported by a reliable method of data collection that consistently obtains the information necessary to identify opportunities for improvement (CD 15–1).	TYPE II
16	I, II, III, IV	The processes of event identification and levels of review must result in the development of corrective action plans, and methods of monitoring, reevaluation, and benchmarking must be present (CD 2–17).	TYPE II
16	I, II, III	Problem resolution, outcome improvements, and assurance of safety ("loop closure") must be readily identifiable through methods of monitoring, reevaluation, benchmarking, and documentation (CD 16–2).	TYPE II
16	I, II, III, IV	Peer review must occur at regular intervals to ensure that the volume of cases is reviewed in a timely fashion (CD 2–18).	TYPE II
16	I, II, III	The trauma PIPS program must integrate with the hospital quality and patient safety effort and have a clearly defined reporting structure and method for provision of feedback (CD 16–3).	TYPE II
16	I, II, III, IV	Because the trauma PIPS program crosses many specialty lines, it must be empowered to address events that involve multiple disciplines and be endorsed by the hospital governing body as part of its commitment to optimal care of injured patients (CD 5–1).	TYPE I
16	I, II, III, IV	There must be adequate administrative support to ensure evaluation of all aspects of trauma care (CD 5–1).	TYPE I
16	I, II, III, IV	The trauma medical director and trauma program manager must have the authority and be empowered by the hospital governing body to lead the program (CD 5–1).	TYPE I
16	I, II, III	The trauma medical director must have sufficient authority to set the qualifications for the trauma service members, including individuals in specialties that are routinely involved with the care of the trauma patient (CD 5–11).	TYPE II

16	I, II, III	Moreover, the trauma medical director must have authority to recommend changes for the trauma panel based on performance review (CD 5–11).	TYPE II
16	I, II, III	The peer review committee must be chaired by the TMD (CD 5-25)	TYPE II
16	I, II, III	In Level I, II, and III trauma centers, representation from general surgery (CD 6-8), and liaisons to the trauma program from emergency medicine (CD 7–11), orthopaedics (CD 9–16), and anesthesiology (CD 11–13), critical care (CD 11-62)—and for Level I and II centers, neurosurgery (CD 8–13), and radiology (CD 11–39)—must be identified and participate actively in the trauma PIPS program with at least 50 percent attendance at multidisciplinary trauma peer review committee.	TYPE II
16	III	Level III centers with any emergent neurosurgical cases must also have the participation of neurosurgery on the multidisciplinary trauma peer review committee (CD 8–13).	Type II
16	I, II	In Level I and II trauma centers, the trauma medical director (CD 5–7), trauma program manager (5–24), and liaisons to the trauma program in emergency medicine (CD 7–12), orthopaedics (CD 9–18), critical care (CD 11–63), and neurosurgery (CD 8–14) must obtain 16 hours annually or 48 hours in 3 years of verifiable, external, trauma-related education (continuing medical education [CME] or CE, as appropriate to the discipline).	Type II
16	I, II, III, IV	The trauma center must demonstrate that all trauma patients can be identified for review (CD 15–1).	TYPE II
16	I, II, III	In Level I, II, and III trauma centers, the trauma registry must submit the required data elements to the NTDB (CD 15–2).	TYPE II
16	I, II, III, IV	The trauma PIPS program must be supported by a registry and a reliable method of concurrent data collection that consistently obtains information necessary to identify opportunities for improvement (CD 15–3).	TYPE II
16	I, II, III	All trauma centers must use a risk adjusted benchmarking system to measure performance and outcomes (CD 15-5).	TYPE II
16	I, II, III	To achieve this goal, a trauma program must use clinical practice guidelines, protocols, and algorithms derived from evidenced-based validated resources (CD 16–4).	TYPE II
16	I, II, III, IV	All process and outcome measures must be documented within the trauma PIPS program's written plan and reviewed and updated at least annually (CD 16–5).	TYPE II
16	I, II, III	Mortality Review (CD 16–6). All trauma-related mortalities must be systematically reviewed and those mortalities with opportunities for improvement identified for peer review. 1. Total trauma-related mortality rates. Outcome measures for total, pediatric (younger than 15 years), and geriatric (older than 64 years) trauma encounters should be categorized as follows: a. DOA (pronounced dead on arrival with no additional resuscitation efforts initiated in the emergency department). b. DIED (died in the emergency department despite resuscitation efforts). c. In-hospital (including operating room). 2. Mortality rates by Injury Severity Scale (ISS) subgroups using Table 1.	TYPE II

16	I, II, III, IV	Trauma surgeon response to the emergency department (CD 2–9). See previous detail.	TYPE II
16	I, II, III, IV	Trauma team activation (TTA) criteria (CD 5–13). See previous detail.	TYPE II
16	I, II, III, IV	All Trauma Team Activations must be categorized by the level of response and quantified by number and percentage, as shown In Table 2 (CD 5–14, CD 5–15).	TYPE II
16	I, II, III	Trauma surgeon response tIme to other levels of TTA, and for back-up call response, should be determined and monitored. Variances should be documented and reviewed for reason for delay, opportunities for improvement, and corrective actions (CD 5–16)	TYPE II
16	I, II, III	Response parameters for consultants addressing time-critical injuries (for example, epidural hematoma, open fractures, and hemodynamically unstable pelvic fractures) must be determined and monitored (CD 5–16).	TYPE II
16	I, II, III	Rates of undertriage and overtriage must be monitored and reviewed quarterly (CD 16–7).	TYPE II
16	I, II, III	Trauma patlent admissions (NTDS definltion) to a nonsurgical service Is higher than 10 percent (CD 5–18).	TYPE II
16	I, II	Pediatric (14 years or younger) trauma care. 1. Trauma centers admitting at least 100 pediatric trauma patients annually requlre a pedlatric-specific trauma PIPS program (CD 10–6). 2. Trauma centers admitting less than 100 pediatric trauma patients annually must review each case for timeliness and appropriateness of care (CD 10–6).	TYPE I
16	I, II, III, IV	Acute transfers out (CD 9–14). All trauma patients who are diverted (CD 3–4) or transferred (CD 4–3) during the acute phase of hospitalization to another trauma center, acute care hospital, or specialty hospital (for example, burn center, reimplantation center, or pediatric trauma center) or patients requiring cardiopulmonary bypass or when specialty personnel are unavailable must be subjected to individual case review to determine the rationale for transfer, appropriateness of care, and opportunities for improvement. Follow-up from the center to which the patient was transferred should be obtained as part of the case review.	TYPE II
16	III	Emergency physicians covering in-house emergencies at Level III trauma centers (CD 7–3). See previous detail.	TYPE II
16	I, II, III	Trauma center diversion-bypass hours must be routinely monitored, documented, and reported, including the reason for initlating the diversion pollcy (CD 3–6), and must not exceed 5 percent.	TYPE II
16	III	Appropriate neurosurgical care at Level III trauma centers (CD 8–9).	TYPE II
16	I, II, III	Availability of the anesthesia service (CD 11–4, CD 11-7, CD 11–16, CD 11-18). • In-house anesthesia servlce (emergency department, intensive care unit, floor, and postanesthesla care unlt) must be avallable for the care of trauma patients • Operating room delays involving trauma patients because of lack of anesthesia support services must be Identified and reviewed to determine the reason for delay, adverse outcomes, and opportunities for improvement.	TYPE II

16	I, II, III	Delay in operating room availability (CD 11–16, CD 11–18) must be routinely monitored. Any case that is associated with a significant delay or adverse outcome must be reviewed for reasons for delay and opportunities for improvement.	TYPE II
16	I, II, III	Response times of operating room and postanesthesia care unit personnel when responding from outside the trauma center (CD 11–16, CD 11–18, CD 11–25) must be routinely monitored.	TYPE II
16	I, II, III	Rate of change in interpretation of radiologic studies (CD 11–32, CD 11–37) should be categorized by RADPEER or similar criteria (describe process/scoring metric used).	TYPE I
16	I, II, III	Response times of computed tomography technologist(30 minutes)/magnetic resonance imaging (60 minutes) technologist/interventional radiology team (30 minutes) when responding from outside the trauma center (CD 11–29, CD 11–30, CD 11–31, CD 11–32, CD 11–33, CD 11–34, CD 11–35, CD 11–36, CD 11-37, and CD 11–46.)	TYPE I
16	I, II, III, IV	Transfers to a higher level of care within the institution (CD 16–8).	TYPE II
16	I, II, III	Solid organ donation rate (CD 16–9).	TYPE II
16	I, II, III, IV	Trauma registry (CD 15–6). See previous detail.	TYPE II
16	I, II, III	Multidisciplinary trauma peer review committee attendance. (Level I, II and III, CD 5-10, CD 6-8, CD 7-11, CD 9-16, CD 11-13, CD 11-62 –and for Level I and II CD 8-13 and CD 11-39)	TYPE II
16	I	Trauma Center Volume (CD 2–4). See previous detail.	TYPE I
16	I, II, III, IV	Sufficient mechanisms must be available to identify events for review by the trauma PIPS program (CD 16–10).	TYPE II
16	I, II, III, IV	Once an event is identified, the trauma PIPS program must be able to verify and validate that event (CD 16–11).	TYPE II
16	I, II, III	There must be a process to address trauma program operational events (CD 16–12).	TYPE II
16	I, II, III	Documentation (minutes) reflects the review of operational events and, when appropriate, the analysis and proposed corrective actions (CD 16–13).	TYPE II
16	I, II, III	Mortality data, adverse events and problem trends, and selected cases involving multiple specialties must undergo multidisciplinary trauma peer review (CD 16–14)	TYPE II
16	I, II, III	This effort may be accomplished in a variety of formats but must involve the participation and leadership of the trauma medical director (CD 5–10); the group of general surgeons on the call panel; and the liaisons from emergency medicine, orthopaedics, neurosurgery, anesthesia, critical care, and radiology ((Level I, II and III, CD 6-8, CD 7-11, CD 9-16, CD 11-13, CD 11-62 - Level I and II centers, CD 8-13 CD 11-39).	TYPE II

16	I, II, III	Each member of the committee must attend at least 50 percent of all multidisciplinary trauma peer review committee meetings (CD 16–15).	TYPE II
16	I, II, III	When these general surgeons cannot attend the multidisciplinary trauma peer review meeting, the trauma medical director must ensure that they receive and acknowledge the receipt of critical information generated at the multidisciplinary peer review meeting to close the loop (CD 16–16).	TYPE II
16	I, II, III	The multidisciplinary trauma peer review committee must systematically review mortalities, significant complications, and process variances associated with unanticipated outcomes and determine opportunities for improvement (CD 16–17).	TYPE II
16	I, II, III	When an opportunity for improvement is identified, appropriate corrective actions to mitigate or prevent similar future adverse events must be developed, implemented, and clearly documented by the trauma PIPS program (CD 16–18).	TYPE II
16	I, II, III	An effective performance improvement program demonstrates through clear documentation that identified opportunities for improvement lead to specific interventions that result in an alteration in conditions such that similar adverse events are less likely to occur (CD 16–19).	TYPE II
Chapter 17: Outreach and Education			
17	I, II, III, IV	All verified trauma centers, however, must engage in public and professional education (CD 17–1).	TYPE II
17	I, II	Level I and II centers also must provide some means of referral and access to trauma center resources (CD 17–2).	TYPE II
17	I	At a minimum, a Level I trauma center must have continuous rotations in trauma surgery for senior residents (Clinical PGY 4–5) that are part of an Accreditation Council for Graduate Medical Education–accredited program (CD 17–3). For pediatric Level I centers, the continuous rotation for surgical residents is extended to include clinical PGY 3 (CD 10-27).	TYPE I
17	I, II, III	In Level I, II, and III trauma centers, the hospital must provide a mechanism to offer trauma-related education to nurses involved in trauma care (CD 17–4).	TYPE II
17	I, II, III, IV	The successful completion of the ATLS® course, at least once, is required in all levels of trauma centers for all general surgeons (CD 6-9), emergency medicine physicians (CD 7-14) and midlevel providers (CD 11-86) on the trauma team.	TYPE II
17	I, II	The trauma director (CD 5-7) and the liaison representatives from neurosurgery (CD 8-14), orthopaedic surgery (CD 9-18), emergency medicine (CD 7-12), and critical care (CD 11-63) must accrue an average of 16 hours annually, or 48 hours in 3 years, of external trauma-related CME.	TYPE II
17	I, II	Other members of the general surgery (CD 6-11), neurosurgery (CD 8-15), orthopaedic surgery (CD 9-19), emergency medicine (CD 7-13), and critical care (CD 11-64) specialties who take trauma call also must be knowledgeable and current in the care of injured patients.	TYPE II

Chapter 18: Prevention			
18	I, II, III, IV	Trauma centers must have an organized and effective approach to injury prevention and must prioritize those efforts based on local trauma registry and epidemiologic data (CD 18–1).	TYPE II
18	I, II, III, IV	Each trauma center must have someone in a leadership position that has injury prevention as part of his or her job description (CD 18-2)	TYPE II
18	I	In Level I centers, this individual must be a prevention coordinator (separate from the trauma program manager) with a job description and salary support (CD 18–2).	TYPE II
18	I, II, III, IV	Universal screening for alcohol use must be performed for all injured patients and must be documented (CD 18–3)	TYPE II
18	I, II	At Level I and II trauma centers, all patients who have screened positive must receive an intervention by appropriately trained staff, and this intervention must be documented (CD 18–4).	TYPE II
18	I, II	Level I and II trauma centers must implement at least two programs that address one of the major causes of injury in the community (CD 18–5).	TYPE II
18	I, II	A trauma center's prevention program must include and track partnerships with other community organizations (CD 18–6).	TYPE II
Chapter 19: Trauma Research and Scholarship			
19	I	For a Level I trauma center, at a minimum, a program must have 20 peer-reviewed articles published in journals included in Index Medicus or PubMed in a 3-year period (CD 19–1).	TYPE II
19	I	These publications must result from work related to the trauma center or the trauma system in which the trauma center participates (CD 19-2)	TYPE II
19	I	Of the 20 articles, at least one must be authored or co-authored by members of the general surgery trauma team (CD 19–3).	TYPE II
19	I	Additionally, at least one article each from three of the following disciplines is required: basic sciences, neurosurgery, emergency medicine, orthopaedics, radiology, anesthesia, vascular surgery, plastics/maxillofacial surgery, critical care, cardiothoracic surgery, rehabilitation, and nursing (CD 19–4).	TYPE II
19	PTC I	The pediatric Level I center's research requirement is equivalent to that of adult Level I trauma centers (CD 10–10).	TYPE II
19	PTC I	In combined Level I adult and [Level I] pediatric centers, half of the research requirement must be pediatric research (CD 10–11).	TYPE II

19	I	In the alternate method, a Level I program must have the following (CD 19–7) a. A program must have 10 peer-reviewed articles published in journals included in Index Medicus or PubMed in a 3-year period. These articles must result from work related to the trauma center or the trauma system in which the trauma center participates. Of the 10 articles, at least one must be authored or co-authored by members of the general surgery trauma team, and at least one article each from three of the following disciplines is required: basic sciences as related to injury, neurosurgery, emergency medicine, orthopaedics, radiology, anesthesia, vascular surgery, plastics/maxillofacial surgery, critical care, cardiothoracic surgery, rehabilitation, and nursing. Trauma-related articles authored by members of other disciplines or work done in collaboration with other trauma centers and participation in multicenter investigations may be included in the remainder. b. Of the following seven trauma-related scholarly activities, four must be demonstrated: • Evidence of leadership in major trauma organizations, which includes membership in trauma committees of any of the regional or national trauma organizations. • Demonstrated peer-reviewed funding for trauma research from a recognized government or private agency or organization. • Evidence of dissemination of knowledge that includes review articles, book chapters, technical documents, Web-based publications, videos, editorial comments, training manuals, and trauma-related educational materials or multicenter protocol development. • Display of scholarly application of knowledge as evidenced by case reports or reports of clinical series in journals included in MEDLINE. • Participation as a visiting professor or invited lecturer at national or regional trauma conferences. • Support of resident participation in mentoring scholarly activity, including laboratory experiences; clinical trials; resident trauma paper competitions at the state, regional, or national level; and other resident trauma presentations. • Mentorship of fellows, as evidenced by the development or maintenance of a recognized trauma, critical care, or acute care surgery fellowship.	TYPE II
19	I	The administration of a Level I trauma center must demonstrate support for the research program by, for example, providing basic laboratory space, sophisticated research equipment, advanced information systems, biostatiscal support, salary support for basic and translational scientists, or seed grants for less experienced faculty (CD 19–8).	TYPE II
Chapter 20: Disaster Planning and Management			
20	I, II, III, IV	Trauma centers must meet the disaster-related requirements of the Joint Commission (CD 20–1).	TYPE II
20	I, II, III	A surgeon from the trauma panel must be a member of the hospital's disaster committee (CD 20–2).	TYPE II
20	I, II, III, IV	Hospital drills that test the individual hospital's disaster plan must be conducted at least twice a year, including actual plan activations that can substitute for drills (CD 20–3)	TYPE II
20	I, II, III, IV	All trauma centers must have a hospital disaster plan described in the hospital's policy and procedure manual or equivalent (CD 20–4).	TYPE II

Chapter 21: Solid Organ Procurement Activities			
21	I, II, III	The trauma center must have an established relationship with a recognized OPO (CD 21–1).	TYPE II
21	I, II, III	A written policy must be in place for triggering notification of the regional OPO (CD 21–2).	TYPE II
21	I, II, III	The trauma center must review its sold organ donation rate annually (CD 16.9).	TYPE II
21	I, II, III, IV	It is essential that each trauma center have written protocols defining the clinical criteria and confirmatory tests for the diagnosis of brain death (CD 21–3).	TYPE II
Chapter 22: Verification, Review, & Consultation Program			
Chapter 23: Criteria quick Reference Guide			
All reference documents will be available at: *https://www.facs.org/quality-programs/trauma/vrc/resources*			

LANDMARK MEDICAL CENTER	Page(s):	3
DEPARTMENTAL POLICIES and PROCEDURES	Saved as:	Trauma Transfer Policy
Subject: Trauma Transfer Policy	Policy #:	
Manual: Administrative Manual	Formulated:	New: 1/2017
Responsible Party: Chief Medical Officer	Reviewed:	
Approved by: Chief Medical Officer	Revised:	

1. **Purpose:**
   To provide appropriate and timely transfer of trauma patients requiring higher level or specialized care. The standards set forth will adhere to applicable legal mandates including but not limited to EMTALA (Emergency Medical Treatment and Active Labor Act).

2. **Equipment/Forms: Transfer forms**

3. **Policy:**
   A. The Emergency Department (ED) physician initiates the transfer process with the receiving trauma center surgeon at a Level I or Level II facility in a timely fashion. This is done after a medical evaluation and stabilization by the ED physician. Mandatory transfer is required for trauma patients with the following conditions:

      a. **HEAD/C-SPINE**
         - Carotid or vertebral artery injury
         - Penetrating injuries or open fracture of the skull
         - GCS score less than 14 or lateralizing neurologic signs (if no neurological consultation is available)
         - Spinal fracture or spinal cord deficit

      b. **CHEST**
         - Cardiac rupture
         - Torn thoracic aorta or great vessel
         - Bilateral pulmonary contusion with PaO2/FIO2 ratio less than 200
         - Bilateral rib fractures (all) OR 2 or more unilateral rib fractures with the presence of pulmonary contusion
         - Significant torso injury with advanced comorbid disease (such as CAP, COPD, type 1 diabetes mellitus, or immunosuppression)

      c. **PELVIS/ABDOMEN**
         - Major abdominal vascular injury
         - Grade IV or V liver injuries
         - Any patient requiring damage control laparotomy
         - Hemodynamically unstable pelvic fracture
         - Complex pelvic/acetabulum fractures

d. **SPINE**
   - Any level spine fracture with neurological deficit
   - Neurologic deficit without spine fracture

e. **EXTREMITIES**
   - Fracture or dislocation with the loss of distal pulses

f. **PEDIATRICS** < 18 (less than or equal to 17) who:
   - Require admission to the hospital
   - Exhibit signs of traumatic brain injury (structural abnormality on x-ray or CT, sustained GCS < 15 for greater than 2 hours, or neurological deterioration)
   - Are being treated non-operatively for solid organ injuries

B. The following trauma patients should be considered for early transfer out:

Burns:
Patients meeting the American Burn Association Criteria for Referral to a Burn Center including but not limited to:

- Partial-thickness burns of greater than 10% of the total body surface area
- Burns that involve the face, hand, feet, genitalia, perineum, or major joints
- Third degree burns any age
- Electrical burns, including lightning injury
- Chemical burns
- Inhalation injury
- Burn injury in patients with pre-existing medical conditions that potentially could prolong recovery or affect mortality
- Any burns with concomitant trauma where the burn poses the greater risk of morbidity or mortality
  - ❖ Physician judgement is necessary and should follow regional medical control plan and triage protocols
- Children who are burned should be transferred to a burn center verified to treat children
  - ❖ In the absence of a designated pediatric burn center, an adult burn center may be utilized as a second option
- Burn injury patients who require specialized social, emotional or rehabilitation services.

Dialysis:
Trauma patients requiring dialysis will be transferred to an appropriate level trauma center with dialysis capabilities

Neuro/Spinal Cord/Spinal Injury

Pediatrics:

- Pediatric patients should be transferred to a Pediatric Trauma Center unless, in the judgement of the referring physician, transfer to such would delay life-saving care that could be provided at a closer Level II or Level I
- Pediatric trauma patients less than or equal to 18 years of age who are injured seriously enough to require hospital admission should be transferred to a Pediatric Trauma Center

C. **Consideration for Transfer**:

- Patients receiving anticoagulant therapy which may place the patient at an increased risk for intracranial hemorrhage or intracranial bleeding

4. **Procedure:**
   - Follow the transfer Policy found in the Administrative Manual

LANDMARK MEDICAL CENTER DEPARTMENTAL POLICIES and PROCEDURES	Page(s):	3
	Saved as:	Transfer Policy
Subject: Transfer Policy	Policy #:	
Manual: Administrative Manual	Formulated:	1/2017
Responsible Party: Chief Nursing Officer	Reviewed:	
Approved by: Chief Nursing Officer	Revised:	

PURPOSE:

To set standards for appropriate transfer of patients to other medical facilities in accordance with applicable legal mandates surrounding the examination, treatment and transfer of individuals who require same or higher level of care, including but not limited to the Emergency Medical Treatment and Active Labor Act ("EMTALA") and the Consolidated Omnibus Budget Reconciliation Act ("COBRA").

To provide guidelines for the appropriate transfer of patients upon discharge from acute care to other facilities such as extended care/nursing homes, rehabilitation center, personal care facilities, mental health or drug/alcohol rehabilitation or home (requiring ambulance transport).

POLICY:

It is the policy of Landmark Medical Center to provide for safe, coordinated and timely transfer of appropriate patients to other facilities. A written physician's order for transfer or discharge is required. All transfers from the Emergency Department, regardless of the level of care, require physician certification for transfer and transfer consent. For patients outside the emergency department, requirements for documentation vary according to the type of transfer: transfer to same or higher level of care or discharge and transfer to extended care or rehabilitation.

PATIENT REQUEST FOR TRANSFER

If the patient or legally responsible person requests the transfer, a request for transfer is documented in the medical record on the Authorization for Transfer.

REFUSAL FOR TRANSFER

If after discussion with the physician, the patient or legally responsible party refuses transfer, refusal will be noted in the medical record and authenticated through signature of the patient or legally responsible person. (See Authorization for Transfer Form)

TRANSFERS TO SAME OR HIGHER LEVEL OF CARE

After evaluation, treatment and stabilization, the attending physician (Emergency Department physician or staff physician) may determine the need to transfer a patient from Lower Bucks Hospital to another facility for definitive care. That transfer may be for, but not limited to, the following situations:

1. Pediatric patients requiring intensive care
2. Burn patients requiring the specialty services of a regional bum center
3. Psychiatric patients requiring inpatient services at a separate psychiatric facility
4. Patients who require subspecialty services not available at Lower Bucks Hospital
5. Patients requesting transfer to another facility

Transfer to the same or higher level of care requires:

1. Physician certification that the patient has been stabilized or if not stabilized, that the transfer is medically necessary and that the medical benefits of transfer outweigh the increased risks, if any, to the patient (Attachment 1– Authorization for Transfer).
2. Consent for transfer by the patient or legally responsible party after explanation of the potential risks and benefits by the physician (Attachment 1).
3. Completion of the Patient Transfer Record – Acute Transfers (Attachment 2).

Procedure:

1. The attending physician will be responsible for the following activities prior to patient transfer:
    1. Examination, treatment and stabilization of patient.
    2. Making arrangements for transfer with a receiving physician and a receiving hospital.
    3. Obtaining appropriate consultations prior to transfer, if deemed necessary.
    4. Determining the level of transport services needed for transfer (ALS vs. BLS).
    5. Completion of the medical record.
    6. Completion of the Authorization for Transfer (Attachment 1).
    7. Completion of the Patient Transfer Record/Acute Transfers (Attachment 2).

2. The nursing staff/unit secretary and/or Social Worker will make arrangements for appropriate transport according to the physician's determination of patient need.

3. Staff will make copies of the appropriate medical records (history and physical exam, laboratory data, x-ray reports, consultation reports and documentation of treatment rendered) and will ensure that these records accompany the patient and the transfer team to the receiving hospital.

4. The RN will contact the receiving hospital specialty care unit (ER, ICU, CCU, etc.) prior to transport to confirm bed availability and to give report to the receiving R.N.

TRANSFER AFTER DISCHARGE TO EXTENDED CARE AND/OR REHABILITATION

The Social Work Services Department will make transfer arrangements for patients discharged to extended care or rehabilitation facilities as requested by the attending physician.

Procedure:

1. Social Service will contact the Admission Office of the receiving facility to confirm the availability of a bed. If Social Service is not available, nursing staff will confirm bed availability before transferring the patient. When bed verification is completed and insurance authorization is obtained, transportation will be arranged and the appropriate people will be notified.

2. The Social Service Department will arrange all transfers/discharges requiring transportation during weekday business hours. During other hours, the individual nursing units or nursing supervisor will make transfer arrangements. On weekends and holidays, the Social Worker can be beeped through the hospital operator, if needed.

3. The Social Worker will notify the nursing personnel regarding the transfer arrangements, i.e. name of the Ambulance Company, date and time of arrival.

4. If the patient is a minor or unable to sign, a family member will accompany the patient to sign records of admissions.

5. A copy of appropriate medical records (see procedure #3 page 2 for acute transfers) and a completed copy of the Patient Transfer Form (Attachment 3) will accompany all transfers to extended care or rehabilitation facilities.

LANDMARK MEDICAL CENTER DEPARTMENTAL POLICIES and PROCEDURES	Page(s):	1 of 1
	Saved as:	Helicopter Transport
Subject: Helicopter Transport Preparation	Policy #:	7012
Manual: Administrative Manual	Formulated:	1989
Responsible Party: Chief Nursing Officer	Reviewed:	1/2017
Approved by: Chief Nursing Officer	Revised:	

PURPOSE:

As necessary and appropriate, patients may be transferred out of Landmark Medical Center via air medical transport (helicopter). Helicopter transfer is appropriate for expedient transfer when time is crucial to trauma, medical or surgical patients.

PROCEDURE:

1. The decision to transfer a patient via helicopter shall be made by the attending physician in collaboration with the Nurse Director/Nursing Coordinator. Landings and take-offs from the helipad at LMC shall only occur during daylight hours. The primary alternate landing site for this community is Barry Field in Woonsocket and will be utilized during night hours.

2. Once the decision has been made, the air medical transport service shall be contacted and provided the necessary medical information. An ETA shall be communicated by the air transport service.

3. The Landmark Facilities Management Department shall be contacted and informed of the ETA if the helicopter is to land at the LMC helipad. Facilities Management will provide traffic control.

4. The Woonsocket Fire Department shall be contacted and informed of the ETA when the helicopter is to land at the Woonsocket Unit. If the patient is being transferred from Barry Field in Woonsocket, the Woonsocket Fire Department is to be notified.

5. A private ambulance service shall be contacted to meet the patient at the helipad and transport the patient to the ED as necessary or to transfer the patient to Barry Field from the ED to meet the helicopter.

6. Safety and security are of the utmost importance during a helicopter transfer. Do not approach the helicopter until signaled to do so by the pilot. Protective eyewear shall be worn by all emergency personnel in approaching the helicopter. All approaches to the helicopter are to be from the front of the helicopter and never from the tail.

Policy

Policy #:7007

DISCHARGE/TRANSFER/AMA

Title of Contact (s): Vice President of Patient Care Services

Date Effective	Supersedes	Date Reviewed/Revised	Page 1 of 3
7/92	5/98	9/03, 3/07, 12/10	

PURPOSE:

1. To provide guidelines for the discharge/transfer of patients.
2. To provide guidelines to health care providers when a patient is determined to leave the hospital against medical advice (AMA).

POLICY:

1. The attending physician/L.I.P. (licensed independent practitioner) will write an order for the discharge or transfer of all patients.

2. Should a patient state his/her determination to leave the hospital against medical advice the attending physician/L.I.P. will be notified immediately.

3. The risks (possible or actual) will be explained by the attending physician/L.I.P. to the patient whenever possible before the patient leaves the hospital

4. Patients who are deemed not to be competent by a physician or pose a threat to themselves or others will not be allowed to leave the hospital against medical advice.

PRACTICE GUIDELINES:

HOME DISCHARGES:

1. The Nurse caring for the patient will review the discharge instructions with the patient/family and answer any questions the patient/family have. Discharge instructions should include information about medications, diet, activity and any other individualized instruction. Patient/family must verbalize understanding of instructions provided. Instructions are documented by the Nurse on the Discharge Instruction Sheet.

2. The patient will be escorted safely to the exit by a member of Nursing or Transport personnel.

   If the patient requests/requires ambulance transport to home/nursing facility upon discharge, Case Management should be notified.

DISCHARGE TO A NURSING FACILITY:

1. Discharge instructions are given as above if the patient is being discharged to a nursing facility.

2. A Continuity of Care Form will be completed by the appropriate health care providers (physician, nurse, physical therapy, nutritionist) on all patients transferred or discharged to another facility.

3. The Case Manager will be responsible for:

   - Placing all three sections of the Form in front of the patient's chart.
   - Notifying Nursing prior to patient's discharge regarding completion of the Continuity of Care Form.
   - Notifying Nutrition Services and Rehabilitation Services prior to patient's discharge.
   - **Nursing** will notify Case Management when form is completed.
   - Assisting staff in completion of the form whenever necessary.

DISCHARGE WITH HOME CARE SERVICES:

1. Discharge instructions are given as above if the patient is being discharged with home care services.

2. Page 1 of the Continuity of Care form will be completed by the appropriate health care providers (physician, nurse, physical therapy, nutritionist) on all patients discharged with home care services.

3. The Case Manager will coordinate home care services. On off shifts and holidays, the nurse will notify the visiting nurse liaison to coordinate home care services.

TRANSFER TO ACUTE FACILITIES:

1. a. It will be the responsibility of the patient's primary physician or his representative to write transfer orders for the patient and physician-to-physician report when appropriate.

   b. Physician will be responsible for completion of the Authorization for Transfer form.

   c. The nurse will be responsible for completing the Non-Emergency Transfer Form. The original form is placed in the patient's chart. A copy is given to the ambulance attendant.

2. A Continuity of Care Form will be completed on all patients transferred or discharged to another facility.

3. Ambulance Determination:

   a. Patients who are being transported to another acute care facility will be transported by ambulance.

b. The physician and nursing staff will determine the level of transport required based on the care needs of the patient. It will be determined whether a nurse needs to accompany the patient based on the care needs of the patient.

AMBULANCE TRANSFER VIA THE EMERGENCY DEPARTMENT:

Ambulance attendants will obtain a completed Non-Emergency Ambulance Transportation Form directly from the Emergency Department physician at the time of transfer if needed. (Please refer to E.D. specific policy on transfers.)

EMERGENCY TRANSFERS:

Emergency/urgent transfers do not require a physician certification for ambulance transport. The Authorization for Transfer form must be completed.

AGAINST MEDICAL ADVICE (AMA):

Patients who insist on leaving the hospital against medical advice must sign the Release From Responsibility For Discharge Form. The nurse must notify the attending physician, as well as the Nurse Manager/Coordinator of the patient's wishes and confer with the physician as to the feasibility of following the patient's request.

ATTACHMENTS:

- Physician Certification Statement for Non-Emergency Medical Transportation Form.
- Authorization for Transfer Form.

LANDMARK MEDICAL CENTER	Page(s):	1
DEPARTMENTAL POLICIES and PROCEDURES	Saved as:	
Subject: Training of Prehospital Personnel in the Community	Policy #:	
Manual: Trauma Manual	Formulated:	1/2017
Responsible Party: Medical Director of Trauma Services	Reviewed:	
Approved by: Chief Nursing Officer	Revised:	

PURPOSE:
To participate in the training of prehospital personnel, the development and improvement of prehospital care protocols, and performance improvement and patient safety programs.

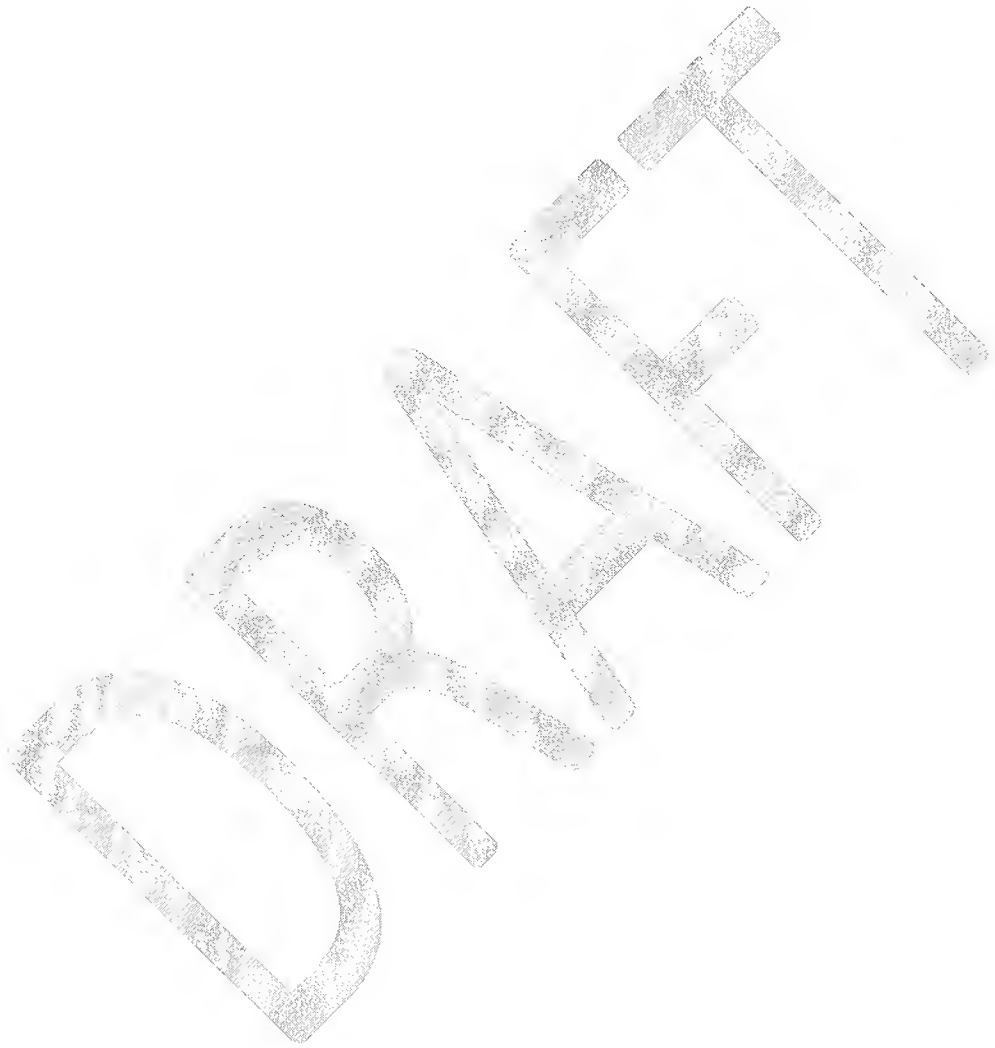
Supportive Data:

The goals of the emergency medical services (EMS) system are to prevent further injury, initiate resuscitation, and provide safe and timely transport of injured patients. Improving the outcome of the trauma patient is dependent upon effectively monitoring, integrating and evaluating patient care in all settings. The trauma program must participate in the education of prehospital personnel both in orientation and continuing education.

Policy:

1. Landmark Medical Center will assist in providing education to personnel in the EMS system including but not limited to, trauma triage criteria, destination protocols, treatment protocols, transportation alternatives, and capabilities of the medical center. Methods of education will consist of Prehosptial Trauma Life Support (PHTLS), grand rounds, trauma conferences and case reviews.
2. Members of the EMS system will be invited to attend performance improvement committee meetings. Agenda items will include review of all cases and identify areas of deficiency and educational plan for follow up.
3. Medical direction will be conducted both on-line and off- line:
    - Off-line medical direction is by protocol (including development, revision, and monitoring by physicians of all operating protocols and procedures, reviewing prehospital reports, and compliance with established procedures
    - On- Line is by two-way voice communication between emergency medical personnel in the field and a physician
4. The medical center will work collaboratively with its Trauma I center to provide annual educational offering to emergency medical services personnel.

References:


DRAFT

LANDMARK MEDICAL CENTER				Page(s):	Page 1 of 11
				Saved As:	PFS-A05
Subject:	Charity Care Policy			Formulated:	01012013
Manual:	Patient Financial Services			Reviewed:	02/2014, 1/2015
Governing Board Approval		Date:		Revised:	02/2014, 1/2015

Policy:

Landmark Medical Center will offer a charity care program for those patients who meet the eligibility tests described below be and comply with the requirements of the Rhode Island's charity care laws (codified under R.I.G.L. § 23-17.14-15).

Procedure:

1. **Eligibility for Participation In Charity Care Program**

A. Self-Pay Patients

A patient qualifies for the Charity Care Program if all of the following conditions are met: (1) the patient does not have third party coverage from a health insurer, health care service plan, union trust plan, Medicare, or Medicaid as determined and documented by the hospital; (2) the patient's injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital; (3) the patient's family income family income does not exceed 350% of the Federal Poverty Level; **and** (4) the patient has monetary assets of less than $10,000.00.

B. Insured Patients

A patient who has third party coverage or whose injury is a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital does not qualify for the Charity Care

Program, but may qualify for the Discount Payment Program if certain conditions are met.

C. Other Circumstances

The Director of the Hospital's Patient Financial Services, (PFS) Department shall also have the discretion to extend charity care or a discount to patients under the following circumstances:

(i) The patient qualifies for limited benefits under the State's Medicaid Program, i.e., limited pregnancy or emergency benefits, but does not have benefits for other services provided at the Hospital.

(ii) The patient qualifies for a Medically Indigent Adult Program offered by a county other than the one in which the Hospital is located.

(iii) Reasonable efforts have been made to locate and contact the patient, such efforts have been unsuccessful, and the PFS Director has reason to believe that the patient would qualify for charity or a discount, i.e., homeless;

(iv) A Third Party Collection Agency has made efforts to collect the outstanding balance and has recommended to the Hospital's PFS Director that charity care or a discount be offered.

D. Definition of Patient's Family & Determination of Family Income

The "patient's family" means the following: (1) for persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and (2) for persons under 18 years of age, parent, caretaker, relatives, and other children under 21 years of age of the parent or caretaker relative.

Documentation of family income shall be limited to recent pay stubs or tax returns.

In determining a patient's monetary assets, the hospital shall not consider retirement or deferred compensation plans qualified under the Internal Revenue Code, non-qualified deferred compensation plans, the first ten thousand dollars ($10,000.00) of monetary assets, and fifty percent (50%) of the patient's monetary assets over the first ten thousand dollars ($10,000.00).

E. Federal Poverty Levels

The measure of 350% of the Federal Poverty Level shall be made by reference to the most up to date Health and Human Services Poverty Guidelines for the number of persons in the patient's family or household. The current Federal Poverty Levels are as follows:

The 2015 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family	Poverty guideline	350% of Poverty Level
1	$11,770	$41,195
2	$15,930	$55,755
3	$20,090	$70,315
4	$24,250	$84,875
5	$28,410	$99,435
6	$32,570	$113,995
7	$36,730	$128,555
8	$40,890	$143,115
For families with more than 8 persons, add $4,020 for each additional person.		

SOURCE: *Federal Register*, Vol. 80, No. 14, January 22, 2015 pp. 3236-3237

2. Charity Care

The patient balances for those patients who qualify to participate in the Charity Care Program, as determined by the hospital, shall be reduced to a sum equal to $0 with the remaining balance eliminated and classified as charity care.

3. Resolution of Disputes

Any disputes regarding a patient's eligibility to participate in the Charity Care Program shall be directed and resolved by the Hospital's Chief Financial Officer.

4. Notices

In order to ensure that patients are aware of the existence of the Charity Care Program, the following actions shall be taken:

A. Written Notice to Patients

Each patient who is seen at Landmark Medical Center, whether admitted or not, shall receive the notice attached hereto as Exhibit 1. The notice shall be provided in non-English languages spoken by a substantial number of the patients served by the Hospital.

B. Posting of Notices

The notice attached hereto as Exhibit 2 shall be clearly and conspicuously posted in locations that are visible to the patients in the following areas: (1) Emergency Department; (2) Billing Office; (3) Admissions Office; and (4) Other Outpatient Settings.

The notice shall be provided in non-English languages spoken by a substantial number of the patients served by the Hospital.

C. Notice to Accompany Bills To Potentially Eligible Patients

Each bill that is sent to a patient who has not provided proof of coverage by a third party at the time care is provided or upon discharge must include a statement of charges for services rendered by the hospital and the notice attached hereto as Exhibit 3. The notice shall be provided in non-English languages spoken by a substantial number of the patients served by the Hospital.

5. Efforts to Obtain Information Regarding Coverage & Applications for Medicaid

Landmark Medical Center shall make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the hospital to a patient including, but not limited to, the following:

(1) Private health insurance; (2) Medicare; and/or (3) the Medicaid program, or other state-funded programs designed to provide health coverage.

If a patient does not indicate that he/she has coverage by a third party payor or requests a discounted price or charity care then the patient shall be provided with an application for the Medicaid program, or other governmental program prior to discharge.

6. Collection Activities

Landmark Medical Center may use the services of an external collection agency for the collection of patient debt. No debt shall be advanced for collection until the Director of the Hospital PFS or his/her designee has reviewed the account and approved the advancement of the debt to collection. Landmark Medical Center shall obtain an agreement from each collection agency that it utilizes to collect patient debt that the agency will comply with the requirements of Rhode Island's charity care laws.

Neither Landmark Medical Center nor any collection agency utilized by Landmark Medical Center shall report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after the initial billing if the patient lacks third party coverage or for a patient that provides information that he or she may qualify for the Charity Care Program.

In addition, if a patient is attempting to qualify for eligibility under Landmark Medical Center s' Charity Care Program or the Discount Payment Policy and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or making regular partial payments of a reasonable amount, the Prime Healthcare Facility shall not send the unpaid bill to any collection agency unless that entity has agreed to comply with Rhode Island's charity care laws.

. Landmark Medical Center shall not, in dealing with patients eligible under the Charity Care Program or the Discount Payment Policy, use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills.

EXHIBIT 1

Charity Care & Discounted Payment Program

Patients who lack insurance or have inadequate insurance and meet certain low- and moderate-income requirements may qualify for discounted payments or charity care. Landmark Medical Center PFS Designee, at the Hospital may be contacted at **401-769-4100 X 2447 or 2449** to obtain further information. The Emergency Department Physicians, who are not employees of the Hospital, may also provide Charity Care or Discounted payment programs. Please contact **401-723-5533** for further information.

Exhibit 2

CHARITY CARE & DISCOUNTED PAYMENT PROGRAM

PATIENTS WHO LACK INSURANCE OR HAS INADEQUATE INSURANCE AND MEET CERTAIN LOW- AND MODERATE-INCOME REQUIREMENTS MAY QUALIFY FOR DISCOUNTED PAYMENTS OR CHARITY CARE. PATIENTS SHOULD CONTACT LANDMARK MEDICAL CENTER PFS DESIGNEE; at **401-769-4100 X 2447 or 2449** TO OBTAIN FURTHER INFORMATION. THE EMERGENCY DEPARTMENT PHYSICIANS, WHO ARE NOT EMPLOYEES OF THE HOSPITAL, MAY ALSO PROVIDE CHARITY CARE OR DISCOUNTED PAYMENT PROGRAMS. PLEASE CONTACT **401-723-5533** FOR FURTHER INFORAMTION.

Exhibit 3

Our records indicate that you do not have health insurance coverage or coverage under Medicare, Medicaid, or other similar programs. If you have such coverage, please contact our office at **401-769-4100 X 2447 or 2449** as soon as possible so the information can be obtained and the appropriate entity billed.

If you do not have health insurance coverage, you may be eligible for Medicare, Medicaid, Landmark Medical Center's Discounted Payment Program, or Charity Care. For more information about how to apply for Medicare, Medicaid, or other similar programs, please contact Landmark Medical Center's PFS Designee at **401-769-4100 X 2447 or 2449** who will be able to answer questions and provide you with applications for these programs.

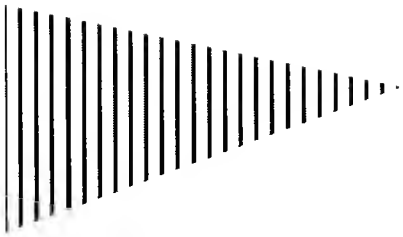
Patients who lack insurance or have inadequate insurance and meet certain low- and moderate-income requirements may qualify for discounted payments or charity care. Patients should contact Landmark Medical Center or PFS Designee, at **401-769-4100 X 2447 or 2449** to obtain further information. The Emergency Department Physicians, who are not employees of the Hospital, may also provide Charity Care or Discounted payment programs. Please contact **401-723-5533** for further information.

20 A

CONSOLIDATED FINANCIAL STATEMENTS

Prime Healthcare Services, Inc. and Subsidiaries
Years Ended December 31, 2015, 2014, and 2013
With Report of Independent Auditors

Ernst & Young LLP



Prime Healthcare Services, Inc. and Subsidiaries

Consolidated Financial Statements

Years Ended December 31, 2015, 2014, and 2013

Contents

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Building a better working world

Report of Independent Auditors

The Board of Directors
Prime Healthcare Services, Inc. and Subsidiaries

We have audited the accompanying consolidated financial statements of Prime Healthcare Services, Inc. and Subsidiaries, which comprise the consolidated balance sheet as of December 31, 2015, and the related consolidated statements of income and comprehensive income, stockholder's equity, and cash flows for the year then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

EY
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Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Prime Healthcare Services, Inc. and Subsidiaries at December 31, 2015, and the consolidated results of their operations and their cash flows for the year then ended, in accordance with U.S. generally accepted accounting principles.

Report of Other Auditors on 2014 and 2013 Financial Statements

The consolidated financial statements of Prime Healthcare Services, Inc. and Subsidiaries for the years ended December 31, 2014 and 2013, were audited by other auditors who expressed an unmodified opinion on those statements on April 29, 2015.

Ernst & Young LLP

May 31, 2016

Prime Healthcare Services, Inc. and Subsidiaries

Consolidated Balance Sheets
(Dollars in Thousands)

	December 31 2015	2014
Assets		
Current assets:		
Cash and cash equivalents*	**$ 113,261**	$ 50,353
Patient accounts receivable, less allowances of $217,182 and $168,704 at December 31, 2015 and 2014, respectively*	**704,093**	483,411
Estimated third-party payor settlements	**51,184**	55,136
Provider fee receivable	**90,355**	166,512
Supplies inventory*	**63,709**	26,269
Prepaid expenses and other current assets*	**91,283**	121,305
Total current assets	**1,113,885**	902,986
Restricted cash	**–**	102,363
Property and equipment, net of accumulated depreciation and amortization*	**1,249,966**	896,426
Insurance claims and reserves recoverable*	**105,490**	104,508
Goodwill	**105,701**	77,229
Other assets*	**46,626**	23,448
Total assets	**$ 2,621,668**	$ 2,106,960

*Account balances contain assets of the consolidated variable interest entities that can only be used to settle obligations of the variable interest entities (see Note 1).

See accompanying notes to consolidated financial statements.

Prime Healthcare Services, Inc. and Subsidiaries

Consolidated Balance Sheets

(Dollars in Thousands, Except Share Data)

	December 31 2015	2014
Liabilities and stockholder's equity		
Current liabilities:		
Accounts payable*	**$ 237,747**	$ 155,695
Accrued expenses*	**174,308**	120,140
Medical claims payable*	**2,298**	2,504
Related party payables	**25,497**	11,694
Line of credit	**175,454**	130,532
Estimated third-party payor settlements	**23,204**	26,669
Provider fee payable	**27,947**	104,051
Current portion of capital leases	**29,971**	18,979
Current portion of long-term debt*	**48,431**	27,675
Total current liabilities	**745,857**	597,939
Long-term liabilities:		
Sale lease-back liability	**478,000**	348,000
Insurance claims liabilities and reserves*	**143,893**	104,508
Pension liabilities	**24,208**	22,549
Capital leases, net of current portion	**108,388**	63,410
Long-term debt, net of current portion*	**691,653**	568,487
Other long-term liabilities	**32,381**	23,565
Total long-term liabilities	**1,478,523**	1,130,519
Stockholder's equity		
Common stock, $0.01 par value, 3,000 shares authorized, 30 shares issued and outstanding	**–**	–
Additional paid in capital	**3**	3
Accumulated other comprehensive loss	**(5,902)**	(2,311)
Retained earnings	**107,624**	181,933
Non-controlling interest	**296,563**	198,877
Total stockholder's equity	**398,288**	378,502
Total liabilities and stockholder's equity	**$ 2,621,668**	$ 2,106,960

*Account balances contain liabilities of the consolidated variable interest entities that can only be used to settle obligations of the variable interest entities (see Note 1).

See accompanying notes to consolidated financial statements.

Prime Healthcare Services, Inc. and Subsidiaries

Consolidated Statements of Income and Comprehensive Income
(Dollars in Thousands)

	Year Ended December 31		
	2015	**2014**	**2013**
Revenue			
Net patient service revenue (net of contractual allowances and discounts)	**$ 3,543,398**	$ 2,627,623	$ 2,349,314
Provision for doubtful accounts	**493,963**	407,321	442,129
Net patient service revenue, less provision for doubtful accounts	**3,049,435**	2,220,302	1,907,185
Premium revenue	**19,535**	17,756	20,228
Other operating revenue	**121,087**	100,120	94,202
	3,190,057	2,338,178	2,021,615
Operating expenses			
Compensation and employee benefits	**1,513,416**	1,096,550	888,930
General and administrative	**421,529**	279,553	309,328
Supplies	**498,976**	344,883	273,756
Professional services	**402,606**	256,697	225,142
Depreciation and amortization	**118,777**	80,112	64,305
Rent and lease	**62,865**	46,300	37,175
Medical claims	**5,965**	3,806	4,131
	3,024,134	2,107,901	1,802,767
Income from operations	**165,923**	230,277	218,848
Interest expense	**(121,120)**	(90,693)	(76,623)
Gain on bargain purchase	**6,461**	–	–
Income before (benefit) provision for income taxes	**51,264**	139,584	142,225
Income tax (benefit) provision	**(2,010)**	3,200	2,137
Net income	**53,274**	136,384	140,088
Allocation of net income to noncontrolling interest	**(98,659)**	(77,798)	(98,377)
Controlling interest in net income	**(45,385)**	58,586	41,711
Other comprehensive loss	**(3,591)**	(2,311)	–
Total comprehensive income	**$ 49,683**	$ 134,073	$ 140,088

See accompanying notes to consolidated financial statements.

Prime Healthcare Services, Inc. and Subsidiaries

Consolidated Statements of Stockholder's Equity

(Dollars in Thousands, Except Share Data)

	Shares	Common Stock	Additional Paid-In Capital	Other Comprehensive Loss	Retained Earnings	Non-Controlling Interest	Total
Balance, December 31, 2012	30	$ –	$ 3	$ –	$ 147,371	$ 141,880	$ 289,254
Distribution of Pampa Regional Medical Center and Pampa Regional Medical Group	–	–	–	–	(28,296)	–	(28,296)
Cash distributions	–	–	–	–	–	(68,758)	(68,758)
Controlling interest in net income	–	–	–	–	41,711	–	41,711
Noncontrolling interest in net income	–	–	–	–	–	98,377	98,377
Balance, December 31, 2013	30	–	3	–	160,786	171,499	332,288
Contributions from stockholder	–	–	–	–	–	50	50
Distribution of La Palma Intercommunity Hospital	–	–	–	–	(37,439)	–	(37,439)
Acquisition of noncontrolling interest of HMC Realty and Harlingen Medical Center	–	–	–	–	–	(9,000)	(9,000)
Unrealized loss in defined benefit pension plan	–	–	–	(2,311)	–	–	(2,311)
Cash distributions	–	–	–	–	–	(41,470)	(41,470)
Controlling interest in net income	–	–	–	–	58,586	–	58,586
Noncontrolling interest in net income	–	–	–	–	–	77,798	77,798
Balance, December 31, 2014	30	–	3	(2,311)	181,933	198,877	378,502
Distribution of Glendora Community Hospital	–	–	–	–	**(28,924)**	–	**(28,924)**
Unrealized loss in defined benefit pension plan	–	–	–	**(3,591)**	–	–	**(3,591)**
Cash distributions	–	–	–	–	–	(973)	(973)
Controlling interest in net income	–	–	–		**(45,385)**	–	**(45,385)**
Noncontrolling interest in net income	–	–	–	–	–	**98,659**	**98,659**
Balance, December 31, 2015	**30**	$ –	$ **3**	$ **(5,902)**	$ **107,624**	$ **296,563**	$ **398,288**

See accompanying notes to consolidated financial statements.

Prime Healthcare Services, Inc. and Subsidiaries

Consolidated Statements of Cash flows

(Dollars in Thousands)

	Year Ended December 31		
	2015	2014	2013
Operating activities			
Net income	$ 53,274	$ 136,384	$ 140,088
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	118,777	80,112	64,305
Loss on sale of assets	15	28	2
Provision for doubtful accounts	493,963	407,321	442,129
Gain on bargain purchase	(6,461)	–	–
Changes in assets and liabilities, net of acquisitions/distributions:			
Patient accounts receivable	(631,933)	(477,635)	(531,756)
Supplies inventory	(17,889)	(2,300)	(926)
Prepaid expenses and other current assets	34,577	9,376	1,264
Other assets	(3,296)	5,787	(1,116)
Related party receivables/payables	13,803	12,640	(5,399)
Accounts payable	74,353	(1,029)	12,858
Accrued expenses, insurance claims liabilities and reserves and other long-term liabilities	59,929	(17,077)	8,307
Medical claims payable	(1,188)	(93)	298
Estimated third-party payor settlements and provider fee	581	(67,000)	(21,316)
Net cash provided by operating activities	188,505	86,514	108,738
Investing activities			
Purchase of property and equipment	(117,433)	(110,860)	(100,518)
Proceeds from sale of property and equipment	–	1,478	–
Cash paid for acquisitions, net of cash acquired	(86,090)	(99,461)	(55,874)
Net cash used in investing activities	(203,523)	(208,843)	(156,392)
Financing activities			
Payments of loan issuance costs	–	–	(8,987)
Proceeds from borrowings on sale lease-back	–	–	75,000
Borrowings on line of credit	2,438,204	1,797,137	1,460,103
Repayments on line of credit	(2,393,282)	(1,776,654)	(1,395,447)
Payments on long-term debt	(53,139)	(4,882)	(1,221)
Payments on capital lease obligations	(24,567)	(9,983)	(8,062)
Proceeds from long-term debt borrowing	26,785	30,000	–
Proceeds from release of restricted cash	85,058	147,651	–
Contributions	–	50	–
Cash distributions	(973)	(41,470)	(68,758)
Cash distributed with distributions of hospitals to stockholder	(160)	(41)	(7,165)
Net cash provided by financing activities	77,926	141,808	45,463
Net increase (decrease) in cash and cash equivalents	62,908	19,479	(2,191)
Cash and cash equivalents, beginning of year	50,353	30,874	33,065
Cash and cash equivalents, end of year	$ 113,261	$ 50,353	$ 30,874

Prime Healthcare Services, Inc. and Subsidiaries

Consolidated Statements of Cash flows
(Dollars in Thousands)

	Year Ended December 31		
	2015	**2014**	**2013**
Supplemental cash flow information			
Cash paid during the year for:			
Interest	**$ 113,836**	$ 97,145	$ 70,153
Income taxes	**$ 3,800**	$ 3,200	$ 2,137
Supplemental disclosure of noncash investing and financing activities			
Financing obligations incurred for the acquisition of property and equipment	**$ 117,655**	$ 62,230	$ 8,191
Property, plant, and equipment included in accounts payable	**$ 7,289**	$ 3,393	$ –
Conversion of MPT operating lease to long term debt	**$ –**	$ 12,500	$ –
Noncash distribution of hospital assets to stockholder	**$ 28,764**	$ 37,398	$ 21,131
Sale lease-back of facilities	**$ 130,000**	$ –	$ 25,000
Debt incurred related to acquisition of hospital facilities	**$ 137,335**	$ –	$ –
Proceeds of restricted cash from issuance of long-term debt	**$ –**	$ 41,000	$ 209,000

See accompanying notes to consolidated financial statements.

1. Basis of Presentation and Significant Accounting Policies

Nature of Business

Prime Healthcare Services, Inc. and Subsidiaries (collectively, the "Company" or "PHSI") owns and operates general acute care hospitals in communities across the United States.

As of December 31, 2015, the Company wholly owned and operated 30 acute care hospitals with 6,095 licensed beds located in various communities in 11 states. The Company's operations also include medical groups and other operations related to its hospital business.

Hospital	Licensed Beds	Location
Desert Valley Hospital	148	Victorville, CA
Chino Valley Medical Center	126	Chino, CA
West Anaheim Medical Center	219	Anaheim, CA
Paradise Valley Hospital	301	National City, CA
Centinela Hospital Medical Center	370	Inglewood, CA
Garden Grove Hospital Medical Center	167	Garden Grove, CA
San Dimas Community Hospital	101	San Dimas, CA
Shasta Regional Medical Center	246	Redding, CA
Alvarado Hospital Medical Center	306	San Diego, CA
Harlingen Medical Center	112	Harlingen, TX
Roxborough Memorial Hospital	140	Philadelphia, PA
Saint Mary's Regional Medical Center	380	Reno, NV
Dallas Medical Center	155	Dallas, TX
Lower Bucks Hospital	160	Bristol, PA
Providence Medical Center	400	Kansas City, KS
Saint John Hospital	80	Leavenworth, KS
Landmark Medical Center	214	Woonsocket, RI
Rehabilitation Hospital of Rhode Island	70	North Smithfield, RI
Garden City Hospital	323	Garden City, MI
Saint Mary's Hospital – Passaic	287	Passaic, NJ
Monroe Hospital*	32	Bloomington, IN
North Vista Hospital*	177	North Las Vegas, NV
Saint Joseph Medical Center*	310	Kansas City, MO
Saint Mary's Medical Center*	146	Blue Springs, MO
Dallas Regional Medical Center*	202	Mesquite, TX
Riverview Regional Medical Center*	281	Gadsden, AL
Lake Huron Medical Center*	164	Port Huron, MI
Saint Clare's (3 hospitals)*	478	Denville, Dover, and Boonton, NJ
Total	6,095	

*Acquired during the year ended December 31, 2015.

1. Basis of Presentation and Significant Accounting Policies (continued)

Principles of Consolidation and Basis of Presentation

The consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("US GAAP") and include the accounts of the Company, its subsidiaries, all of which are controlled by the Company through majority voting control, and variable interest entities for which the Company is the primary beneficiary.

The Company has a variable interest in the medical groups and other entities. The other entities primarily consist of Prime Healthcare Management, Inc. ("PHM") and Prime Healthcare Management II, Inc. ("PHM II"). PHM and PHM II provide management services to PHSI and Prime Healthcare Foundation, Inc. ("PHF"), respectively. The Company has determined that the medical groups are variable interest entities due to the equity interest holder's lack of ability to exercise control. The Company has determined that the other entities are variable interest entities due to a lack of sufficient equity at risk. The Company has also determined it is the primary beneficiary of the medical groups and other entities because the Company has the power to direct activities that most significantly impact the economic performance of these entities. Accordingly, the Company has consolidated these entities. The creditors of these variable interest entities do not have recourse to the general credit of the primary beneficiary.

All intercompany accounts and transactions have been eliminated upon consolidation. Non-controlling interests in less-than-wholly-owned consolidated subsidiaries of the Company are presented as a component of total equity to distinguish between the interests of the Company and the interests of the noncontrolling owners.

The equity of the variable interest entities has been reflected as a noncontrolling interest as of December 31, 2015 and 2014. The consolidation of these entities does not change any legal ownership, and does not change the assets or the liabilities and equity of PHSI as a stand-alone entity. These entities had total revenues of approximately $246,969,000, $172,510,000, and $183,953,000 for the years ended December 31, 2015, 2014, and 2013, respectively.

1. Basis of Presentation and Significant Accounting Policies (continued)

Total assets and total liabilities as of December 31 are as follows (in thousands):

	December 31	
	2015	**2014**
Assets		
Current assets:		
Cash and cash equivalents	**$ 7,798**	$ 2,961
Patient accounts receivable, net	**5,589**	5,514
Supplies inventory	**34**	38
Related party receivables	**300,121**	248,497
Notes receivable	**550**	–
Prepaid expenses and other current assets	**2,619**	12,188
Total current assets	**316,711**	269,198
Property and equipment, net	**71,208**	32,096
Insurance claims and reserves recoverable	**2,893**	4,582
Goodwill	**7,571**	–
Other assets	**3,679**	3,833
Total assets	**$ 402,062**	$ 309,709
Liabilities		
Current liabilities:		
Accounts payable	**$ 14,140**	$ 5,539
Accrued expenses	**8,407**	6,094
Medical claims payable	**161**	122
Current portion of long-term debt	**9,054**	5,768
Total current liabilities	**31,762**	17,523
Insurance claims liabilities and reserves	**4,003**	4,582
Long-term debt, net of current portion	**58,130**	70,585
Total liabilities	**$ 93,895**	$ 92,690

The balances reflected above in related party receivables are from entities owned by PHSI and are eliminated on consolidation with PHSI.

1. Basis of Presentation and Significant Accounting Policies (continued)

Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Revenues are recorded during the period the health care services are provided, based upon the estimated amounts due from the patients and third-party payors. In some cases, reimbursement is based on formulas which cannot be determined until cost reports are filed and audited or otherwise settled by the various programs. See Note 2 for further discussion of the Company's payment arrangements with its third-party payors.

The following is a summary of sources of net patient service revenues (net of contractual allowances and discounts) less provision for doubtful accounts (amounts in thousands):

	Year Ended December 31		
	2015	**2014**	**2013**
Medicare	**$ 971,746**	$ 722,038	$ 677,851
Medicare Managed Care	**316,254**	239,888	209,556
Medicaid	**405,405**	289,833	244,027
Medicaid Managed Care	**508,463**	363,018	265,756
Commercial – contracted	**401,292**	210,351	200,560
Commercial – non-contracted	**327,321**	310,829	212,771
Self-pay/other	**118,954**	84,345	96,664
	$ 3,049,435	$ 2,220,302	$ 1,907,185

Charity Care

The Company provides care to patients who lack financial resources and are deemed to be medically indigent based on criteria established under the Company's charity care policy. This care is provided without charge or at amounts less than the Company's established rates. Because the Company does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. The direct and indirect costs related to this care totaled approximately $37,465,000, $32,628,000, and $26,309,000 for the years ended December 31, 2015, 2014, and 2013, respectively. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross

1. Basis of Presentation and Significant Accounting Policies (continued)

uncompensated charges associated with providing care to charity patients. In addition, the Company provides services to other medically indigent patients under various state Medicaid programs. Such programs pay amounts that are less than the cost of the services provided to the recipients. The Company has not changed its charity care or uninsured discount policies during the years ended December 31, 2015, 2014, or 2013.

Allowance for Contractual Adjustments and Doubtful Accounts

The Company's patient accounts receivable are reduced by allowances for contractual adjustments and doubtful accounts. In evaluating the collectability of patient accounts receivable, the Company analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowances for both contractual adjustments and doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of these allowances. For receivables associated with self-pay patients (which include both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Company records a provision for doubtful accounts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the expected rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

Premium Revenue and Medical Claims Expense

The Company has agreements with various Health Maintenance Organizations ("HMO") to provide medical services to enrollees. Under these agreements, the Company receives monthly premium revenue based on the number of each HMO's enrollees, regardless of services actually performed by the Company. Premium revenue under HMO contracts is recognized during the period in which the Company is obligated to provide services. Certain HMO contracts also contain shared-risk provisions whereby the Company can earn additional incentive revenue or incur penalties based upon the utilization of inpatient hospital services by assigned HMO enrollees. The Company estimates shared-risk revenue and expenses based upon inpatient utilization.

The cost of health care services consists primarily of capitation and claims payments, pharmacy costs, and incentive payments to contracted providers. These costs are recognized in the period incurred, or when the services are provided. Claims costs also include an estimate of the cost of

1. Basis of Presentation and Significant Accounting Policies (continued)

services which have been incurred but not yet reported to the Company. The estimate for accrued medical costs is based on projections of costs using historical studies of claims paid and adjusted for seasonality, utilization, and cost trends. These estimates are subject to trends in loss severity and frequency. Although considerable variability is inherent in such estimates, management records its best estimate of the amount of medical claims incurred at each reporting period. Estimates are continually monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Such projections are adjusted and estimates changed when developments of claims information are warranted. There was no significant impact to the 2015, 2014, and 2013 operating results due to changes in this estimate.

Supplies Inventory

Supplies inventory is stated at the lower of cost, determined by the average cost method, or market. Inventories consist primarily of medical and surgical supplies and pharmaceuticals.

Property and Equipment

Property and equipment is stated at cost or, in the case of acquisitions, at their acquisition fair values. Depreciation is computed using the straight-line method over the estimated useful lives of the assets, which range from three to thirty years. Amortization of leasehold improvements is computed over the lesser of the lease term and the estimated useful lives of the assets and is included in depreciation and amortization expense. Equipment capitalized under capital lease obligations is amortized over the lesser of the life of the lease or the useful life of the asset.

Long Lived Assets and Amortizable Intangible Assets

The Company reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying value of such assets may not be recoverable. The Company considers assets to be impaired and writes them down to fair value if estimated undiscounted cash flows associated with those assets are less than their carrying amounts. Fair value is based upon the present value of the associated cash flows. Changes in circumstances (for example, changes in laws or regulations, technological advances or changes in strategies) may also reduce the useful lives from initial estimates. Changes in planned use of intangibles may result from changes in customer base, contractual agreements, or regulatory requirements. In such circumstances, management will revise the useful life of the long-lived asset and amortize the remaining net book value over the adjusted remaining useful life. There were no impairments of long-lived assets and amortizable intangible assets recorded during the years ended December 31, 2015, 2014, or 2013.

1. Basis of Presentation and Significant Accounting Policies (continued)

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Principal areas requiring the use of estimates include third-party settlements, settlements under shared-risk programs, allowances for contractual discounts and doubtful accounts, accruals for medical claims, impairment of goodwill, long-lived assets and intangible assets, professional and general liability claims, and reserves for legal contingencies.

Income Taxes

The Company has elected to be taxed under the provisions of subchapter S of the Internal Revenue Code ("IRC"). Under these provisions, the Company does not pay federal corporate income taxes on its taxable income. However, the Company is subject to a 1.5% California franchise tax along with applicable income taxes in states where the Company has operations. The stockholder of PHSI is taxed on their proportionate share of the Company's taxable income as defined by the IRC. The Company distributes funds necessary to satisfy the stockholder's tax liability. As of December 31, 2015 and 2014, the accumulated previously taxed income that could be distributed to the S corporation stockholder on a tax free basis was approximately $198 million and $185 million, respectively; all of which was attributable to noncontrolling interests.

The literature related to uncertain tax positions prescribes a recognition threshold and measurement process for accounting for uncertain tax positions and also provides guidance on various related matters such as derecognition, interest, penalties and disclosures required. The Company does not have any entity level uncertain tax positions. The Company files income tax returns in the U.S. federal jurisdiction and various state jurisdictions. Generally, the Company is subject to examination by U.S. federal (or state and local) income tax authorities for three years from the filing of a tax return.

Deferred tax assets and liabilities are recorded for differences between the financial statement and tax basis of the assets and liabilities that will result in taxable or deductible amounts in the future based on enacted laws and rates applicable to the periods in which the differences are expected to affect taxable income. The major components of the Company's deferred tax assets relate to the

1. Basis of Presentation and Significant Accounting Policies (continued)

allowance for doubtful accounts and fixed assets. The deferred tax assets are reflected in prepaid expenses and other current assets and the deferred tax liabilities are reflected in other long-term liabilities on the accompanying consolidated balance sheets.

Cash and Cash Equivalents

The Company considers all highly liquid investments with an original maturity of three months or less when purchased to be cash equivalents.

Restricted Cash

Restricted cash consists of proceeds from the amended and restated revolving and term loan and security agreement (see Note 6). The proceeds of the term loan are classified as restricted cash, and the Company must meet certain term loan draw conditions before funds can be disbursed, including permitted target acquisitions, certain acquisition-related capital expenditures, or permitted acquisition-related working capital funding, as defined in the amended and restated revolving and term loan and security agreement. Restricted cash was $0 and $102,363,000 at December 31, 2015 and 2014, respectively. The balance at December 31, 2015 is $0 because all remaining restricted cash was used during 2015 for acquisitions.

Other Assets

Other assets consists of costs associated with the issuance of debt, which are amortized to interest expense over the term of the related debt. Amortization of deferred financing costs totaled $3,259,000, $2,613,000, and $1,438,000 for the years ended December 31, 2015, 2014, and 2013, respectively. Deferred financing costs, net of accumulated amortization, totaled $11,830,000 and $13,922,000 at December 31, 2015 and 2014, respectively (see Notes 6 and 7). Other assets also consists of intangible assets arising from business combinations (see Note 4) and equity method investments.

Goodwill

Goodwill represents the excess of the consideration paid and liabilities assumed over the fair value of the net assets acquired, including identifiable intangible assets.

1. Basis of Presentation and Significant Accounting Policies (continued)

Goodwill arising from business combinations is not amortized. Management evaluates goodwill on an annual basis and whenever events and changes in circumstances suggest that the carrying amount may not be recoverable. The Company tests for goodwill as of December 31 each year. Impairment of goodwill is tested at the reporting unit level by comparing the reporting unit's carrying amount, including goodwill, to the fair value of the reporting unit. The fair value of the reporting units are estimated using a discounted cash flow approach. If the carrying amount of the reporting unit exceeds fair value, goodwill is considered impaired and a second step is performed to measure the amount of impairment loss, if any.

As of December 31, 2015 and 2014, the management of the Company determined that impairment did not exist. However, if estimates or the related assumptions change in the future, the Company may be required to record impairment charges to reduce the carrying amount of this asset.

Fair Value of Financial Instruments

The Company's consolidated balance sheets include the following financial instruments: cash and cash equivalents, patient accounts receivable, accounts payable, accrued expenses, and long-term debt. The Company considers the carrying amounts of current assets and current liabilities in the consolidated balance sheets to approximate the fair value of these financial instruments and their expected realization.

The carrying values and the fair values of non-current financial liabilities are as follows (amounts in thousands):

	December 31			
	2015		2014	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
Liabilities:				
Long-term debt	$ 691,653	$ 515,309	$ 568,487	$ 429,084

The fair value of the Company's long-term debt was determined based on market prices.

1. Basis of Presentation and Significant Accounting Policies (continued)

Concentration of Credit Risk

Cash and cash equivalents are maintained at financial institutions and, generally, balances may exceed federally insured limits of $250,000 per depositor of each financial institution. The Company has not experienced any losses to date related to these balances. Management monitors the financial condition of these institutions on an ongoing basis and does not believe any significant credit risk exists as of December 31, 2015.

At December 31, 2015 and 2014, patient accounts receivable were comprised of the following government programs; Medicare 34% and 34%, respectively; Medicaid 31% and 31%, respectively; health maintenance and preferred provider organizations (managed care programs) 14% and 13%, respectively; and private pay and commercial insurance patients 13% and 22%, respectively. Management believes there are minimal credit risks associated with receivables from government programs. Receivables from managed care programs and others are from various payors who are subject to differing economic conditions and do not represent concentrated risks to the Company. Management continually monitors and adjusts the reserves associated with receivables.

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, *Revenue from Contracts with Customers*, which outlines a single comprehensive model for recognizing revenue and supersedes most existing revenue recognition guidance, including guidance specific to the healthcare industry. ASU 2014-09 will require new and enhanced disclosures. Companies can adopt the new standard either using the full retrospective approach, a modified retrospective approach with practical expedients, or a cumulative effect upon adoption approach. ASU 2014-09 was originally intended to become effective for annual and interim reporting periods beginning after December 15, 2016, for public companies and become effective for annual reporting periods beginning after December 15, 2017, and interim reporting periods beginning after December 15, 2018, for private companies. However, in July 2015 the FASB issued a final ASU (ASU 2015-14, *Revenue from Contracts with Customers (Topic 606): Deferral of Effective Date*), that defers the effective date by one year, with early adoption permitted. The Company plans to adopt this ASU on January 1, 2019, and is currently evaluating plans for adoption and the impact on the Company's revenue recognition policies, procedures and control framework and the resulting impact on the consolidated financial position, results of operations, and cash flows.

1. Basis of Presentation and Significant Accounting Policies (continued)

In April 2015, the FASB issued ASU 2015-03, *Interest – Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs*, which requires debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct reduction from the carrying amount of that debt liability, consistent with the accounting for debt discounts. The ASU did not change the measurement or recognition guidance for debt issuance costs. This ASU is effective for fiscal years beginning after December 31, 2015, with early adoption permitted. The Company plans to adopt this ASU on January 1, 2016, which will result in the reclassification of approximately $11.8 million of debt issuance costs from other long-term assets to a reduction of the related long-term debt.

In September 2015, the FASB issued ASU 2015-16, *Business Combinations (Topic 805): Simplifying the Accounting for Measurement-Period Adjustments*. ASU 2015-16 eliminates the requirement to restate prior period financial statements for measurement period adjustments. The new guidance requires that the cumulative impact of a measurement period adjustment (including the impact on prior periods) be recognized in the reporting period in which the adjustment is identified. In addition, separate presentation on the face of the income statement or disclosure in the notes is required regarding the portion of the adjustment recorded in the current period earnings, by line item that would have been recorded in previous reporting periods if the adjustment to the provisional amounts had been recognized as of the acquisition date. ASU 2015-16 is to be applied prospectively for measurement period adjustments that occur after the effective date. ASU 2015-16 is effective for annual reporting periods, including interim reporting periods, beginning after December 15, 2015, and early adoption is permitted. Because it is prospective, the impact of ASU 2015-16 on the Company's financial condition and earnings will depend upon the nature of any measurement period adjustments identified in future periods.

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842)*. The new standard establishes a right-of-use ("ROU") model that requires a lessee to record a ROU asset and a lease liability on the balance sheet for all leases with terms longer than 12 months. Leases will be classified as either finance or operating, with classification affecting the pattern of expense recognition in the income statement. The new standard will become effective for annual reporting periods beginning after December 15, 2018, including interim periods within those fiscal years for public companies, and will become effective for annual reporting periods beginning after December 15, 2019, and interim reporting periods beginning after December 15, 2020, for private companies. A modified retrospective transition approach is required for lessees for capital and

1. Basis of Presentation and Significant Accounting Policies (continucd)

operating leases existing at, or entered into after, the beginning of the earliest comparative period presented in the financial statements, with certain practical expedients available. The Company is currently evaluating the impact of its pending adoption of the new standard on its consolidated financial statements.

In May 2015, the FASB issued ASU 2015-07, *Fair Value Measurement (Topic 820): Disclosures for Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent).* ASU 2015-07 removes the requirement to categorize within the fair value hierarchy investments for which fair values are estimated using the net asset value practical expedient provided by Accounting Standards Codification Topic 820, *Fair Value Measurement.* Disclosures about investments in certain entities that calculate net asset value per share are limited under ASU 2015-07 to those investments for which the entity has elected to estimate the fair value using the net asset value practical expedient. ASU 2015-07 is effective for entities (other than public business entities) for fiscal years beginning after December 15, 2016, with retrospective application to all periods presented. Early application is permitted. The Company has elected to early adopt ASU 2015-07 in the year ended December 31, 2015.

Reclassifications

Certain prior year amounts on the balance sheet, primarily related to estimated third-party payor settlements and provider fees, were reclassified to conform to the current year presentation. There was no change in reported net income or stockholder's equity related to these reclassifications.

2. Revenue Recognition

The Company has arrangements with third-party payors that provide for payments to the Company at amounts different from its established rates. A summary of the payment arrangements with major third- party payors are as follows:

Medicare

Inpatient acute-care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Medicare reimburses the Company for covered

2. Revenue Recognition (continued)

outpatient services rendered to Medicare beneficiaries by way of an outpatient prospective payment system based on ambulatory payment classifications. The Company's classification of patients under the Medicare program and the appropriateness of their admissions are subject to an independent review.

Inpatient non-acute services, certain outpatient services, medical education costs, and defined capital costs related to Medicare beneficiaries are paid based, in part, on a cost reimbursement methodology. The Company is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. The estimated amounts due to or from the program are reviewed and adjusted annually based on the status of such audits and any subsequent appeals. Differences between final settlements and amounts accrued in previous years are reported as adjustments to net patient service revenue in the year that examination is substantially completed. These differences increased net patient service revenue by approximately $12,497,000, $13,747,000, and $5,621,000 for the years ended December 31, 2015, 2014, and 2013, respectively. The Company does not believe that there are significant credit risks associated with this government agency.

Medicaid

Inpatient services rendered to Medicaid program beneficiaries in the states in which the Company operates are reimbursed under a prospective payment system. Outpatient services are reimbursed based on a mixture of fee schedules and a cost reimbursement methodology. The Company is reimbursed for cost reimbursable services at tentative rates with final settlement determined after submission of annual cost reports and audits thereof by the Medicaid fiscal intermediaries. The Company also participates in Medicaid managed care arrangements. Payments for services of Medicaid beneficiaries that participate in those programs include prospectively determined rates and fee schedule payments. The estimated amounts due to or from the Medicaid fiscal intermediaries are reviewed and adjusted annually based on the status of such audits and any subsequent appeals. Differences between final settlements and amounts accrued in previous years are reported as adjustments to net patient service revenue in the year examination is substantially complete. These differences decreased net patient service revenue by approximately $3,367,000, $459,000, and $6,163,000 for the years ended December 31, 2015, 2014, and 2013, respectively. The Company does not believe that there are significant credit risks associated with these government agencies.

2. Revenue Recognition (continued)

Insurance, Health Maintenance Organizations and Preferred Provider Organizations

The Company has also entered into agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the Company under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

Other

The Company also provides its services to patients enrolled in programs of commercial insurance carriers, health maintenance organizations and preferred provider organizations under which the Company does not have agreements. The Company recognizes revenue for these patients based on its usual and customary rates for these services, as adjusted for historical trends in the Company's reimbursement for similar services.

Laws and regulations governing the third-party payor arrangements are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Normal estimation differences between subsequent cash collections on patient accounts receivable and net patient accounts receivable estimated in the prior year are reported as adjustments to net patient service revenue in the current period. These differences decreased net patient service revenue by approximately $50,090,000, $55,330,000, and $10,102,000 for the years ended December 31, 2015, 2014, and 2013, respectively.

Meaningful Use Incentives

The American Recovery and Reinvestment Act of 2009 ("ARRA") established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified electronic health record ("EHR") technology. The Medicare incentive payments are paid out to qualifying hospitals over four consecutive years on a transitional schedule. To qualify for Medicare incentives, hospitals and physicians must meet EHR "meaningful use" criteria that become more stringent over three stages designated by the Centers for Medicare and Medicaid ("CMS").

2. Revenue Recognition (continued)

Medicaid programs and payment schedules vary from state to state. The Medicaid programs required hospitals to register for the program prior to 2016, to engage in efforts to adopt, implement or upgrade certified EHR technology in order to qualify for the initial year of participation, and to demonstrate meaningful use of certified EHR technology in order to qualify for payment for up to three additional years.

For the years ended December 31, 2015, 2014, and 2013, the Company recorded revenues of approximately $18,955,000, $21,845,000, and $20,054,000, respectively, related to the Medicare and Medicaid programs in the consolidated statements of income and comprehensive income. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria. Subsequent changes to these estimates will be recognized in the consolidated statements of income and comprehensive income in the period in which additional information is available. Such estimates are subject to audit by the federal government, the state or its designee.

California Hospital Fee Program

The California Hospital Quality Assurance Fee Program (the "Program") is comprised of four laws enacted by the state of California. The four laws cover the periods from April 1, 2009 through December 31, 2010 (the "Twenty Month Program"); January 1, 2011 through June 30, 2011 (the "Six Month Program"); July 1, 2011 through December 31, 2014 (the "Thirty Month Program"); and January 1, 2014 through December 31, 2016 (the "Thirty Six Month Program"). The Program requires a Quality Assurance Fee ("QA Fee") to be paid by certain hospitals to a State fund established to accumulate the assessed QA Fees and receive matching federal funds. QA Fees and corresponding matching federal funds are then paid to participating hospitals in two supplemental payment methodologies: a fee-for service supplement payment methodology and a managed care plan methodology. In the Thirty Six Month Program, the managed care plan methodology is split between expansion and non-expansion components.

CMS approved California's State Plan Amendment and Waivers as of October 8, 2010, May 18, 2011, June 22, 2012, and December 5, 2014, allowing the State to implement the QA Fee and the fee-for-service Supplement Payment methodology of the legislation for the Twenty Month, Six Month, Thirty Month, and Thirty Six Month programs. CMS approved the managed care plan methodology on January 18, 2011, and December 29, 2011, for the Twenty Month and Six Month Programs, respectively. The managed care plan methodology for the Thirty Month Program was

2. Revenue Recognition (continued)

approved by CMS (first 24 months approved in May 2013 and last six months approved in November 2014). On June 30, 2015, CMS approved the non-expansion component of the managed care plan methodology relating to the first six months of the Thirty Six Month Program, through June 30, 2014. In April 2016, CMS approved the expansion component of the managed care plan methodology relating to the first six months of the Thirty Six Month Program, through June 30, 2014. CMS has not yet approved the managed care plan methodology for the remainder of the Thirty Six Month Program.

Based on formulas contained in the legislation as well as modeling done by the California Hospital Association, the Company recognized supplemental payments, included in net patient service revenue, and quality assurance fee expense, included in general and administrative expenses in the accompanying consolidated statements of income and comprehensive income as follows (in thousands):

	Year Ended December 31		
	2015	**2014**	**2013**
Net patient service revenue	**$ 143,480**	$ 190,834	$ 179,186
General and administrative expense	**(114,654)**	(119,929)	(128,526)
Net pre-tax impact of California hospital fee program	**$ 28,826**	$ 70,905	$ 50,660

Amounts recorded on the balance sheet with respect to the California hospital fee program are included in provider fee receivable and provider fee payable.

3. Acquisitions and Distributions

Acquisitions

During the years ended December 31, 2015, 2014, and 2013, the Company entered into the following acquisitions and distributions. All business combinations were consistent with the Company's strategic growth plan and were accounted for using the acquisition method of accounting. Operating results for each of the acquisitions have been included in the accompanying consolidated financial statements from the date of acquisition. Operating results for the distributions have been included in the accompanying consolidated financial statements through

3. Acquisitions and Distributions (continued)

the date of distribution. The goodwill arising is primarily attributable to the synergies expected to arise after the acquisitions, and is expected to be deductible for tax purposes for entities that were asset acquisitions. While goodwill is generally not expected to be deductible for tax purposes for entities that were stock acquisitions, the Company has made an IRC Section 338(h)(10) election in respect of the acquisition of North Vista Hospital, and accordingly that acquisition will be treated for tax purposes as if it was an asset acquisition.

During 2015, the Company acquired 10 hospitals:

Facility	Acquisition Date	Type
Monroe Hospital	January 1, 2015	Asset
North Vista Hospital (1)	January 22, 2015	Stock
St. Joseph Medical Center (2)	February 13, 2015	Asset
St. Mary's Medical Center (2)	February 13, 2015	Asset
Riverview Regional Medical Center (1)	March 1, 2015	Asset
Dallas Regional Medical Center (1)	March 1, 2015	Asset
Lake Huron Medical Center (3)	September 1, 2015	Asset
St. Clare's (3 hospitals) (4)	October 1, 2015	Asset

(1) Acquisition includes hospital along with medical groups.
(2) These two hospitals were acquired under one transaction (called "Carondelet" in the acquisition table below) and include various physician groups, clinics, and home health services.
(3) Facility was formerly known as St. Joseph Mercy Port Huron.
(4) The purchase price allocation for St. Clare's is preliminary with respect to the valuation of certain working capital items.

3. Acquisitions and Distributions (continued)

The following table presents the allocation of the aggregate purchase price for each of the hospitals purchased in 2015 (amounts in thousands):

	Monroe Hospital	North Vista Hospital	Carondelet	Dallas Regional Medical Center
Cash	$ 2,873	$ 513	$ 870	$ –
Patient accounts receivable	3,041	14,234	27,229	–
Supplies inventory	1,222	2,421	5,096	2,106
Prepaid expenses	51	1,397	2,171	486
Property and equipment	2,822	18,742	110,393	19,550
Intangible assets	480	1,860	6,980	1,250
Goodwill	–	3,777	591	2,055
Bargain gain	(6,461)	–	–	–
Other assets	–	108	3,767	30
Liabilities	(2,228)	(6,433)	(8,096)	(477)
Cash consideration	$ 1,800	$ 36,619	$ 149,001	$ 25,000

	Riverview Regional Medical Center	Lake Huron Medical Center	Saint Clare's	Total
Cash	$ –	$ 3	$ 8	$ 4,267
Patient accounts receivable	–	6,789	33,198	84,491
Supplies inventory	4,540	1,695	3,044	20,124
Prepaid expenses	831	1,059	1,427	7,422
Property and equipment	16,860	16,721	47,235	232,772
Intangible assets	1,470	1,450	4,520	18,010
Goodwill	1,632	–	14,416	22,471
Bargain gain	–	–	–	(6,461)
Other assets	312	1,163	203	5,583
Liabilities	(1,544)	(1,973)	(16,801)	(37,552)
Cash consideration	$ 24,101	$ 26,907	$ 87,250	$ 350,678

3. Acquisitions and Distributions (continued)

In connection with the acquisition of Monroe Hospital, the Company recorded a bargain gain of $6,461,000, which is included in gain on bargain purchase in the accompanying consolidated statements of income and comprehensive income. Additionally, the Company entered into a lease for the facility which was classified as a capital lease (see Note 8). The bargain gain arose because the facility was previously in bankruptcy and there were no other offers for the facility.

On October 30, 2015, High Desert Heart Vascular Institute ("HDHVI") entered into an asset purchase agreement with High Desert Heart Institute and A&A Surgery Center for HDHVI to acquire certain assets of those companies. The purchase price is $10,000,000, of which $3,500,000 was paid upon closing. The remaining amount of $6,500,000 is deferred as of December 31, 2015, with $500,000 due in October 2018 and $1,000,000 due each year from 2020 through 2025. These deferred amounts have been recorded at a present value of approximately $4,177,000 as of the date of acquisition. Net assets acquired were approximately $106,000 and the difference of approximately $7,571,000 (after present valuing the deferred payments) was recorded to goodwill.

Additionally during 2015, the Company purchased various medical groups for approximately $1.7 million, of which approximately $576,000 was allocated to goodwill. Goodwill related to acquisitions of medical groups in 2014 and 2013 of approximately $234,000 has been reclassified to goodwill from other assets in 2015.

During 2014, the Company acquired five hospitals:

Facility	Acquisition Date	Type
Landmark Medical Center (1)	January 1, 2014	Asset
Rehabilitation Hospital of Rhode Island (1)	January 1, 2014	Asset
Garden City Hospital	July 1, 2014	Asset
Glendora Community Hospital (2)	May 22, 2014	Asset
St. Mary's Hospital Passaic	August 15, 2014	Asset

(1) These two hospitals were acquired under one transaction and also includes Landmark Physician Office Services.
(2) Facility was formerly known as East Valley Hospital Medical Center.

3. Acquisitions and Distributions (continued)

The following table presents the allocation of the aggregate purchase price for each of the hospitals purchased in 2014 (amounts in thousands):

	Landmark Medical Center	Rehabilitation Hospital of Rhode Island	Garden City Hospital
Cash	$ 6,610	$ 40	$ 4,702
Patient accounts receivable	10,455	921	14,240
Supplies inventory	1,529	24	1,451
Prepaid expenses	471	34	1,342
Property and equipment	18,123	–	41,296
Intangible assets	–	–	–
Goodwill	–	–	–
Other assets	5,457	4	–
Liabilities	(27,545)	(430)	(35,495)
Cash consideration	$ 15,100	$ 593	$ 27,536

	Glendora Community Hospital	Saint Mary's Hospital – Passaic	Total
Cash	$ 374	$ 262	$ 11,988
Patient accounts receivable	1,125	13,364	40,105
Supplies inventory	218	2,578	5,800
Prepaid expenses	469	2,110	4,426
Property and equipment	16,173	38,196	113,788
Intangible assets	570	3,720	4,290
Goodwill	2,381	37,730	40,111
Other assets	382	–	5,843
Liabilities	(4,811)	(55,621)	(123,902)
Cash consideration	$ 16,881	$ 42,339	$ 102,449

3. Acquisitions and Distributions (continued)

On July 31, 2014, the Company acquired an additional 32.1% of equity interest in Harlingen Medical Center for $5,600,000, which increased its equity interest in Harlingen Medical Center from 67.9% to 100%. On July 31, 2014, the Company acquired an additional 18.7% equity interest in HMC Realty for $4,400,000, then sold 4.7% of its interest to other HMC Realty shareholders for $1,000,000. As of December 31, 2015 and 2014, the Company's equity interest in HMC Realty is 50%.

During 2013, the Company acquired two general acute care hospitals and a medical group.

On January 18, 2013, the Company entered into an asset purchase agreement with Sisters of Charity of Leavenworth Health System, Inc., pursuant to which the Company acquired certain assets and liabilities of Providence Medical Center and Saint John Hospital.

The following table presents the allocation of the aggregate purchase price for each of the three acquisitions consummated in 2013 (amounts in thousands):

	Providence Medical Center	Saint John Hospital	Providence Place, Inc. and Physician Resources, Inc.	Total
Cash	$ –	$ –	$ 1,210	$ 1,210
Patient accounts receivable	–	–	1,184	1,184
Supplies inventory	1,020	373	108	1,501
Prepaid expenses	752	70	452	1,274
Property and equipment	41,828	8,945	1,276	52,049
Intangible assets	2,600	440	165	3,205
Goodwill	1,655	–	–	1,655
Liabilities	(2,803)	(555)	(1,636)	(4,994)
Cash consideration	$ 45,052	$ 9,273	$ 2,759	$ 57,084

3. Acquisitions and Distributions (continued)

Distributions

Effective December 31, 2015, December 31, 2014, and December 31, 2013 the Company distributed its ownership interests in Glendora Community Hospital ("Glendora"), La Palma Intercommunity Hospital ("La Palma"), and Pampa Regional Medical Center and Pampa Regional Medical Group (collectively, "Pampa"), respectively, to PHF on behalf of its controlling stockholder.

The following table summarizes the carrying amounts of the components of assets and liabilities distributed (amounts in thousands):

	Glendora	La Palma	Pampa
Cash	$ 160	$ 41	$ 7,165
Patient accounts receivable, net	2,520	9,756	7,696
Supplies inventory	612	420	746
Prepaid expenses	719	3,014	539
Estimated third-party payor settlements	(41)	566	589
Property and equipment	22,517	17,711	11,013
Other assets	2,770	5,931	548
Insurance claims liabilities and reserves	(333)	–	–
	$ 28,924	$ 37,439	$ 28,296

All liabilities of Glendora, La Palma, and Pampa were retained by PHSI in conjunction with the distributions, except for the estimated third party settlements and insurance claims liabilities and reserves of Glendora, which were distributed to PHF.

4. Goodwill and Other Intangible Assets

Goodwill

The changes in the carrying amount of goodwill for the years ended December 31 are as follows (amounts in thousands):

	2015	2014
Balance, beginning of year	**$ 77,229**	$ 38,882
Goodwill acquired as part of acquisitions during current year	**30,853**	40,111
Distributions to controlling stockholder	**(2,381)**	(1,764)
Balance, end of year	**$ 105,701**	$ 77,229

Intangible Assets

The Company's intangible assets consist of tradenames, which were acquired in connection with acquisitions, and are being amortized between 10–15 years.

The gross carrying amount of the Company's tradenames was $25,649,000 and $7,666,000 at December 31, 2015 and 2014, respectively, and the net carrying amount was $22,859,000 and $6,967,000 at December 31, 2015 and 2014, respectively.

The weighted-average remaining amortization period for the intangible assets subject to amortization is approximately 12 years. There are no expected residual values related to these intangible assets.

4. Goodwill and Other Intangible Assets (continued)

Amortization expense on these intangible assets was $2,091,000, $657,000 and $295,000 during the years ended December 31, 2015, 2014, and 2013, respectively. Expected amortization expense on intangible assets for the five years subsequent to December 31, 2015, and thereafter, are as follows (amounts in thousands):

Years ending December 31:	
2016	$ 2,564
2017	2,514
2018	2,514
2019	2,193
2020	1,551
Thereafter	11,523
	$ 22,859

5. Property and Equipment

Property and equipment consist of the following at December 31 (amounts in thousands):

	2015	2014
Land	**$ 135,448**	$ 109,059
Buildings	**679,690**	499,157
Building improvements	**39,009**	26,518
Equipment	**680,687**	454,909
Construction in progress (estimated cost to complete is approximately $63,497 and $69,356 at December 31, 2015 and 2014, respectively)	**130,647**	111,135
	1,665,481	1,200,778
Less: Accumulated depreciation and amortization	**(415,515)**	(304,352)
	$ 1,249,966	$ 896,426

Depreciation expense was $116,686,000, $79,455,000, and $64,010,000 for the years ended December 31, 2015, 2014, and 2013, respectively.

5. Property and Equipment (continued)

Gross property and equipment includes approximately $153,525,000 and $71,504,000 of equipment under capital lease arrangements as of December 31, 2015 and 2014, respectively. Related accumulated amortization totaled approximately $27,830,000 and $15,462,000 as of December 31, 2015 and 2014, respectively. Amortization of equipment held under capital leases is included in the depreciation and amortization amounts disclosed above.

Included within equipment is capitalized software costs, which relate to significant system conversions. The estimated amortization period is five years. The gross carrying amount of capitalized software for internal use was approximately $39,014,000 and $4,821,000 at December 31, 2015 and 2014, respectively, and the net carrying amount considering accumulated amortization was approximately $34,691,000 and $4,821,000 at December 31, 2015 and 2014, respectively. There is no expected residual value for capitalized internal-use software. At December 31, 2015, there was approximately $4,057,000 of capitalized costs for internal-use software that is currently in the development stage and will begin amortization once the software project is complete and ready for its intended use. Amortization expense was $4,323,000 for the year ended December 31, 2015. There was no expense during the years ended December 31, 2014 and 2013.

6. Line of Credit

On July 3, 2012, the Company entered into a revolving loan and security agreement with Healthcare Finance Group, LLC ("HFG") with a total available amount of $175,000,000. The line of credit was scheduled to mature on July 15, 2016, with an interest rate of LIBOR (with a LIBOR floor of 1.25%) plus 3.5%.

In conjunction with the Company's refinancing of its revolving loan and security agreement on July 3, 2012, the Company also restructured its obligations with subsidiaries of Medical Properties Trust, Inc. ("MPT" or the "REIT"), a health care real estate investment trust, with whom the Company has entered into various real estate transactions. The Company also entered into a loan agreement with MPT of Inglewood, L.P. for $100,000,000, as well as a cross-collateralization and cross-guarantee agreement with the Company's other obligations due to MPT. This agreement included properties that are owned by Prime A Investments, LLC (the "Prime A properties") (related party, see Note 10) for which the Company is also obligated to repay in the collateralization and guarantee agreements.

6. Line of Credit (continued)

On December 19, 2013, the Company entered into an amended and restated revolving and term loan and security agreement with HFG. This agreement increased the maximum available line of credit amounts to $225,000,000. HFG swept the hospitals' governmental payor and non-governmental payor lockboxes on a daily basis, with swept amounts being applied against the outstanding line of credit balance. The line of credit accrued interest at LIBOR (with a LIBOR floor of 1.00%) plus 3.25%. At December 31, 2015, the interest rate was 4.25%. Balances outstanding as of December 31, 2015 and 2014, were approximately $175,454,000 and $130,532,000, respectively. The line of credit was originally scheduled to mature on December 19, 2018, but was refinanced in 2016, see Note 14.

7. Long-Term Debt

Long-term debt consists of the following as of December 31 (amounts in thousands):

	Maturity	Terms	Interest Rates (4)	2015	2014
Loan with MPT secured by Desert Valley Hospital and Chino Valley Medical Center facilities	July 2022	(1) (2)	11.09%	$ **140,000**	$ 140,000
Loan refinanced with MPT, secured by real property of Desert Valley Hospital	December 2016	(1) (2)	11.00%	**12,500**	12,500
Loan with MPT, secured by real property of Centinela Hospital Medical Center	July 2022	(1) (2)	10.96%	**100,000**	100,000
Note payable with MPT secured by certain property and equipment and lease deposits of Paradise Valley Hospital	July 2022	(1) (2)	10.59%	**25,000**	25,000
Note payable with MPT secured by certain property and equipment and lease deposits of Monroe Hospital	January 2025	(1) (2)	8.50%	**5,000**	5,000
Note payable with MPT secured by certain property and equipment and lease deposits of St. Joseph Medical Center and St. Mary's Medical Center	February 2025	(1) (2)	8.50%	**40,000**	–

7. Long-Term Debt (continued)

	Maturity	Terms	Interest Rates (4)	2015	2014
Note payable with MPT secured by certain property and equipment and lease deposits of Lake Huron Medical Center	September 2025	(1) (2)	8.50%	**$ 10,000**	$ –
Note payable with MPT secured by certain property and equipment and lease deposits of St. Clare's Hospital	October 2025	(1) (2)	8.50%	**100,000**	–
Term loans with BBVA Compass, secured by certain real property	June 2019	Principal and interest of $153,000 payable monthly	4.97%	**30,376**	32,217
Term loan with Siemens Financial Services, secured by certain equipment of Prime Healthcare Air Transport LLC	2017	Principal and interest of $75,000 payable monthly	6.77%	**1,473**	2,240
Term loan with HFG, secured by the assets of the Company	December 2018	(3)	5.75%	**214,834**	250,000
Promissory note with Desert Valley Insurance Limited, unsecured	June 2019	Principal and interest due on maturity; fixed	6.00%	**30,000**	25,000
IBM notes for software and services	Various from October 2019 to November 2020	Principal and interest of $421,000 payable monthly; variable	4.20% to 5.39%	**15,332**	4,087

7. Long-Term Debt (continued)

	Maturity	Terms	Interest Rates (4)	2015	2014
Note payable with EPIC	January 2019	(5)	4.25% (5)	$ 7,322	$ –
Other				8,247	118
				740,084	596,162
Less: current portion				(48,431)	(27,675)
				$ 691,653	$ 568,487

(1) Monthly payments of interest are due; the interest rates are subject to annual escalation increases of the greater of 2% or the consumer price index.
(2) Subject to financial and non-financial covenants. The Company was in compliance with such covenants at December 31, 2015.
(3) The Company's revolving loan and security agreement with HFG was subject to certain financial covenants. The debt was refinanced subsequent to year end (see Note 14).
(4) As of December 31, 2015.
(5) The note is at an interest rate of 0% and, accordingly, the Company has imputed interest at an annual rate of 4.25% on this note payable. Payments are due monthly.

On December 19, 2013, the Company entered into an amended and restated revolving and term loan and security agreement with HFG, which increased the available line of credit (see Note 6) and included a term loan of up to $250,000,000. The land and buildings of the hospitals acquired with the term loan proceeds became the collateral of the term loan. As of December 31, 2015, these hospitals included Landmark Medical Center, Rehabilitation Hospital of Rhode Island, Garden City Hospital, St Mary's Passaic Hospital, North Vista Hospital, Dallas Regional Medical Center, and Riverview Regional Medical Center. The term loan accrued interest at LIBOR (with a LIBOR floor of 1.25%) plus 4.50%. The term loan was originally scheduled to mature on December 18, 2018, but was refinanced in January 2016 (see Note 14). Accordingly, covenant compliance was not required to be tested at December 31, 2015.

Prime A Investments, LLC ("Prime A"), a company which is under common ownership as the Company, has title to and leases the Desert Valley Hospital and Chino Valley Medical Center facilities to the Company. In respect of the related debt due to MPT, the Company and Prime A are co-borrowers on the loan. The loan is reflected on the financial statements of the Company under accounting literature that requires an entity to measure obligations that it expects to pay on behalf of its co-obligors.

7. Long-Term Debt (continued)

Aggregate annual principal maturities of long-term debt for the five years subsequent to December 31, 2015, and thereafter, are as follows (amounts in thousands):

Years ending December 31	
2016	$ 48,431
2017	35,443
2018	173,715
2019	59,563
2020	1,738
Thereafter	421,194
	$ 740,084

8. Leases

From 2007 to 2011 the Company entered into various transactions with subsidiaries of MPT, a health care real estate investment trust. The Company sold to MPT real estate and hospital buildings that had been acquired as part of acquisitions of Paradise Valley Hospital (May 2007), San Dimas Community Hospital (November 2008), Garden Grove Hospital Medical Center (November 2008) and Alvarado Hospital Medical Center (February 2011). In conjunction with these transactions, the Company leased back the real estate and hospital buildings for periods of 10 years, with options to extend the term of the lease for three additional five year periods. In each case, the Company has the option to purchase the leased properties for a value which is pre-determined at the start of the lease. These transactions do not qualify for sale leaseback accounting because of the Company's deemed continuing involvement with the buyer-lessor due to fixed price renewal options and the requirement to pay reserves for major repairs, which is a form of contingent collateral, and the pre-determined option price, which results in the transaction being recorded under the financing method. Under the financing method, the assets remain on the consolidated balance sheet and the proceeds from the transactions are recorded as a financing liability.

On July 3, 2012, the Company entered into a master lease agreement, which replaced the existing leases, to lease the hospital properties and related medical office buildings as noted in the above paragraph. All of the legal entities that are parties to the master lease agreement (which are the hospital entities themselves, as well as PHSI and Prime A) provide cross guarantees on all of the obligations to MPT, which guarantees include both lease payments under the master lease as well as indebtedness due to MPT. Prime A's guarantee is limited to the indebtedness for which it is a

8. Leases (continued)

co-borrower ($140 million, see Note 6 and below). In connection with the master lease agreement, the then-existing leases were reset to new 10-year terms with options to extend the term by two 60 month periods. Monthly rent is defined as 10.75% of the lease base, subject to annual escalation of the greater of 2% or the consumer price index. The Company has the option to buy the properties at a price that is fixed at the time of entering into the lease. Due to the guarantee and option to purchase included in the lease, this transaction was recognized as a finance obligation.

In 2012 and 2013, the Company entered into additional transactions with MPT. The Company sold to MPT real estate and hospital buildings that had been acquired as part of acquisitions of Roxborough Memorial Hospital (September 2012), Saint Mary's Regional Medical Center (September 2012), Providence Medical Center and Saint John's Hospital (June 2013). Concurrent with these agreements, the Company entered into an amendment to the master lease agreement whereby the hospital properties and related medical office buildings were added to the master lease and accordingly the terms of these transactions (and the accounting treatment) are the same as described above.

During 2015, in connection with the acquisitions of Saint Joseph Medical Center in Kansas City, MO, and Saint Mary's Medical Center in Blue Springs, MO (February 2015), and Lake Huron (September 2015) the Company sold the related real estate and hospital buildings to MPT, then the Company leased back the real estate and hospital buildings for periods of 10 years, with options to extend the term of the lease for two additional five-year periods. Monthly rent is defined as 8.50% of the lease base, subject to annual escalation of the greater of 2% or the consumer price index. The Company has the right of first refusal to purchase the properties for the price that a third party offers. These transactions do not qualify for sale leaseback accounting because of the Company's deemed continuing involvement with the buyer-lessor, including the requirement to pay reserves for major repairs, which is considered a form of contingent collateral and results in the transaction being recorded under the financing method.

8. Leases (continued)

The Company's sale leaseback liabilities consist of the following; monthly rents stated are as of December 31, 2015 (amounts in thousands):

Hospital	Monthly Rent	December 31 2015	2014
Paradise Valley Hospital	$ 210	**$ 23,000**	$ 23,000
Alvarado Hospital Medical Center	639	**70,000**	70,000
San Dimas Community Hospital	119	**13,000**	13,000
San Dimas Medical Office Building	64	**7,000**	7,000
Garden Grove Hospital Medical Center	148	**16,250**	16,250
Garden Grove Medical Office Building	80	**8,750**	8,750
Roxborough Memorial Hospital	274	**30,000**	30,000
Saint Mary's Regional Medical Center	731	**80,000**	80,000
Dallas Medical Center	228	**25,000**	25,000
Providence Medical Center	548	**60,000**	60,000
Saint John Hospital	137	**15,000**	15,000
Saint Joseph Medical Center	567	**80,000**	–
Saint Mary's Medical Center	213	**30,000**	–
Lake Huron Hospital	142	**20,000**	–
	$ 4,100	**$ 478,000**	$ 348,000

In addition to the hospital facilities operated under the above sale leaseback transactions and the related party agreements for Desert Valley Hospital and Chino Valley Medical Center's hospital buildings (see Note 10), the Company has also entered into the following leases (as part of the master lease agreement):

The Company leases the hospital properties and related other medical office buildings for West Anaheim Medical Center and Shasta Regional Medical Center from MPT. All leases under this master lease agreement have a 10-year term (through July 2022) with options to extend the term by two 60 month periods. Monthly rent is defined as 10.75% of the lease base, subject to annual escalation of the greater of 2% or the consumer price index. These leases are accounted for as operating leases, whereby no liability is recorded on the Company's financial statements. The West Anaheim Medical Center facility includes monthly rent payments of approximately $228,000 at December 31, 2015. The Shasta Regional Medical Center facility includes monthly rent payments of approximately $576,000 at December 31, 2015.

8. Leases (continucd)

On January 1, 2015, the Company entered into a lease agreement with MPT in connection with the acquisition of Monroe Hospital. This lease has been recorded as a capital lease on the consolidated balance sheet, with an initial value of approximately $9,300,000. The lease includes monthly rent payments of approximately $213,000 at December 31, 2015.

The Company leases medical office buildings under master lease agreements with subsidiaries of Prime A (see Note 10).

Lease expense, consisting primarily of building rent and equipment leases, amounted to approximately $62,865,000, $46,300,000, and $37,175,000 for the years ended December 31, 2015, 2014, and 2013, respectively, net of sublease income of $1,637,000, $1,412,000, and $1,258,000 for the years ended December 31, 2015, 2014, and 2013, respectively.

Capital leases bear interest at rates ranging from 1.34% to 10.44% and have maturity dates through March 1, 2025.

8. Leases (continued)

As of December 31, 2015, future minimum lease payments under non-cancelable operating leases (with initial or remaining lease terms in excess of one year) and future minimum capital lease payments are (amounts in thousands):

	Capital Leases	Operating Lease Commitments	Sale Leaseback Commitments
Years ending December 31:			
2016	$ 38,008	$ 36,621	$ 50,186
2017	37,344	32,583	51,190
2018	34,937	27,988	52,214
2019	28,232	25,598	53,258
2020	12,868	23,187	54,323
Thereafter	16,897	80,366	618,015
	168,286	226,343	879,186
Less: Non-cancellable subleases	–	(7,914)	–
Total minimum payments	168,286	$ 218,429	879,186
Less: Amounts representing interest	(29,927)		(401,186)
	138,359		478,000
Less: Current portion	(29,971)		–
	$ 108,388		$ 478,000

9. Professional Liability, Workers' Compensation, Healthcare and Earthquake Insurance

Desert Valley Insurance Limited ("DVIL") provides workers' compensation, professional liability, medical insurance, and earthquake insurance coverage to the Company. DVIL is owned by Prime A, a company which is under common ownership as the Company.

Workers' Compensation Insurance

Under the terms of the policies DVIL is obligated to insure each workers' compensation claim up to a maximum of $1,000,000 per claim. Losses in excess of $1,000,000 per claim are insured by the Safety National Insurance Company.

9. Profcssional Liability, Workers' Compensation, Healthcare, and Earthquake Insurance

Professional Liability Insurance

DVIL provides professional liability insurance on a claims-made basis. Under this policy, insurance premiums cover only those claims actually reported during the policy term. Should the claims made policy not be renewed or replaced with equivalent insurance, claims related to occurrences during the policy term but reported subsequent to the policy's termination may be uninsured. Under the current policy, the medical groups of PHSI are covered up to $1,000,000 per claim and $3,000,000 general aggregate limit with no deductible. The hospitals of PHSI are covered up to $3,000,000 per claim and $30,000,000 general aggregate limit with no deductible. Excess losses up to an additional $25,000,000 per incident and $50,000,000 general aggregate are insured by Lexington Insurance Company. The Company renewed its claims made policy with DVIL for the next policy year ending December 31, 2016, under the same terms.

US GAAP requires that a healthcare facility recognize the estimated costs of malpractice claims in the period of the incident of malpractice, if it is reasonably possible that liabilities may be incurred and losses can be reasonably estimated. The claims reserve is based on the best data available to the Company; however, the estimate is subject to a significant degree of inherent variability.

The estimate is continually monitored and reviewed, and as the reserve is adjusted, the difference is reflected in current operations. While the ultimate amount of professional liability is dependent on future developments, management is of the opinion that the associated liabilities recognized in the accompanying consolidated financial statements are adequate to cover such claims. Management is aware of no potential professional liability claims whose settlement, if any, would have a material adverse effect on the Company's consolidated financial position.

Earthquakc and Flood Insurance

Under the DVIL policy, insurance premiums cover only those claims which occurred during the policy term. Should the claims made policy not be renewed, or replaced with equivalent insurance, claims related to occurrences during the policy term but reported subsequent to the policy's termination may be uninsured under the current policy. The Company is covered up to $30,000,000 per occurrence and in the aggregate subject to a five percent deductible. The Company renewed its policy through June 30, 2016.

9. Professional Liability, Workers' Compensation, Healthcare, and Earthquake Insurance (continued)

Medical Insurance

The Company began a medical insurance program with DVIL for healthcare coverage for employees effective January 1, 2010. The Company has renewed this policy through December 31, 2016. Under the terms of the policy, DVIL is obligated to insure each employee medical claim subject to a deductible of $500 per covered claim. Claims are adjudicated by an independent third-party administrator.

The Company has evaluated whether they are required to consolidate DVIL in accordance with applicable literature related to variable interest entities as of December 31, 2015, and has determined that DVIL is not a variable interest entity. The Company is not exposed to the risk that it may be required to subsidize the losses, if any of DVIL.

10. Related-Party Transactions

Amounts due (to) from related parties as of December 31 are as follows (amounts in thousands):

	2015	2014
Prime Healthcare Foundation, Inc. and subsidiaries	$ (7,487)	$ (7,487)
Desert Valley Insurance Limited	(15,855)	(5,204)
Prime A Investments, LLC	(1,975)	1,023
Other	(180)	(26)
	$ (25,497)	$ (11,694)

10. Related-Party Transactions (continued)

The Company has entered into certain agreements with PHF, a related party. Under these agreements, (i) PHM II provides management services to PHF; (ii) Bio-Med, Inc. provides asset management services, including but not limited to repairs and maintenance of medical equipment, to PHF; and (iii) Hospital Business Services, Inc. provides outsourced business office services to PHF. Fees relating to these agreements totaled approximately $31,681,000, $26,096,000, and $5,925,000 for the years ended December 31, 2015, 2014, and 2013, respectively, and are included in other operating revenues in the consolidated statements of income and comprehensive income.

The Company has entered into agreements with DVIL to provide workers' compensation, earthquake insurance coverage, commercial malpractice liability insurance and healthcare insurance for employees (see Note 9), and healthcare insurance for employees.

The Company leases certain medical office buildings and parking facilities under master lease agreements with subsidiaries of Prime A. The leases are for five year terms. Rent expense incurred under these leases was approximately $20,784,000, $8,034,000, and $8,038,000 for the years ended December 31, 2015, 2014, and 2013, respectively. The Company subleases some of the office space under the master lease agreements to third party tenants.

The Company leases the hospital facilities at Desert Valley Hospital and Chino Valley Medical Center from Prime A, see Notes 6 and 8.

See Note 7 for details of note payable to DVIL.

11. Retirement Savings Plan

The Company has a defined contribution retirement plan covering substantially all of its employees. The Company's contribution to the plan is at the Company's discretion but limited to the maximum amount deductible for federal income tax purposes under the applicable Internal Revenue Code. During the years ended December 31, 2015, 2014, and 2013, the Company made contributions of approximately $12,809,000, $8,747,000, and $6,914,000, respectively, to the plan.

12. Defined Benefit Pension Plan

The sponsorship for the Garden City Hospital Osteopathic Employee Pension Plan (the "Plan") was changed to Prime Healthcare Services – Garden City, LLC upon acquisition of this hospital on July 1, 2014. The Plan covers substantially all eligible employees of Garden City Hospital hired prior to 2003, as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), with at least 1,000 hours worked in each Anniversary Year (as defined). Entry into the Plan was frozen effective May 15, 2003, and benefit accruals were frozen effective May 15, 2004.

The Company recognizes the funded status (i.e., the difference between the fair value of plan assets and the projected benefit obligations) of this pension plan in the consolidated balance sheets. For the year ended December 31, 2015 and the period from July 1, 2014 to December 31, 2014, the unrealized losses related to this pension plan were approximately $3,591,000 and $2,311,000, respectively.

Benefit Obligations, Fair Value of Plan Assets and Funded Status

The following table provides a reconciliation of the changes in the benefit obligation and fair value of plan assets for the year ended December 31, 2015, and the period from July 1, 2014 to December 31, 2014, and a statement of funded status as of December 31, 2015 and 2014 (amounts in thousands):

	2015	2014
Change in projected benefit obligation:		
Benefit obligation at beginning of period:	$ 75,830	$ 73,227
Interest cost	2,799	1,437
Actuarial (gain) loss	(119)	2,853
Benefits paid	(3,438)	(1,687)
Projected benefit obligation at end of period	$ 75,072	$ 75,830
Change in plan assets:		
Fair value of plan assets at beginning of period:	$ 53,281	$ 51,689
Actual return on plan assets	(304)	2,014
Employer contributions	1,325	1,265
Benefits paid	(3,438)	(1,687)
Fair value of plan assets at end of period	$ 50,864	$ 53,281
Underfunded status at end of period	$ (24,208)	$ (22,549)

12. Defined Benefit Pension Plan (continued)

The change in the actuarial loss for the year ended December 31, 2015, and the period from July 1, 2014 to December 31, 2014, is attributable to the change in the discount rate utilized to determine the benefit obligation amount. During the year ended December 31, 2015, net actuarial losses increased the benefit obligation by $1,659,000. These losses are recorded in accumulated other comprehensive income ("AOCI") and are reflected in the table below. During the period from July 1, 2014 to December 31, 2014, net actuarial losses increased the benefit obligation by $1,010,000. These losses are recorded in AOCI and are reflected in the table below.

The Company estimates that it will make a contribution to the Plan of approximately $714,000 in 2016.

Information for the pension plan which has an accumulated benefit obligation in excess of plan assets as of December 31 (amounts in thousands) is as follows:

	2015	2014
Projected benefit obligation	$ **75,072**	$ 75,830
Accumulated benefit obligation	$ **75,072**	$ 75,830
Fair value of plan assets at measurement date	$ **50,864**	$ 53,281

Net Periodic Costs

A summary of the components of net pension expense for the year ended December 31, 2015 and the period from July 1, 2014 to December 31, 2014, are as follows (amounts in thousands):

	2015	2014
Interest cost	$ **2,799**	$ 1,437
Expected return on plan assets	**(3,406)**	(1,473)
Net pension expense	$ **(607)**	$ (36)

12. Defined Benefit Pension Plan (continued)

Assumptions

The assumptions used to determine the benefit obligations at December 31 are as follows:

	2015	2014
Weighted-average discount rate	**4.25%**	3.78%
Rate of compensation increase	**N/A**	N/A

The assumptions used to determine the net pension expense for the year ended December 31, 2015 and the period from July 1, 2014 to December 31, 2014, are as follows:

	2015	2014
Weighted-average discount rate	**3.78%**	4.05%
Weighted-average expected long-term rate of return on plan assets	**6.50%**	6.50%

Basis used to determine expected long-term return on plan assets

The expected long-term return on plan assets assumption was developed as a weighted average rate based on the target asset allocation of the plan and the Long-Term Capital Market Assumptions ("CMA") 2014. The capital market assumptions were developed with a primary focus on forward-looking valuation models and market indicators. The key fundamental economic inputs for these models are future inflation, economic growth, and interest rate environment. Due to the long-term nature of the pension obligations, the investment horizon for the CMA 2014 is 20 to 30 years. In addition to forward-looking models, historical analysis of market data and trends was reflected, as well as the outlook of recognized economists, organizations and consensus CMA from other credible studies.

Benefit Payments

Benefit payments in the table below are based on the same assumptions used to measure the related benefit obligations and are paid from both funded benefit plan trusts and current assets. Actual benefit payments may vary significantly from these estimates.

12. Defined Benefit Pension Plan (continued)

The following table summarizes the expected benefit payments to be paid (amounts in thousands):

Years ending December 31:	
2016	$ 3,720
2017	3,800
2018	3,890
2019	3,990
2020	4,240
Years 2021–2025	23,370

Benefit Plan Assets Measured at Fair Value on a Recurring Basis

Fair value is defined as an exit price, representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants. Fair value is a market-based measurement that is determined based on assumptions that market participants would use in pricing an asset or liability.

Level 1 – Observable inputs such as quoted prices in active markets;

Level 2 – Inputs, other than quoted prices in active markets, that are observable either directly or indirectly; and

Level 3 – Unobservable inputs in which there is little or no market data, which require the reporting entity to develop its own assumptions.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

12. Defined Benefit Pension Plan (continued)

The fair values of the pension plan assets at December 31 by asset class are as follows (amounts in thousands):

	Fair Value Measurements Using			
	Level 1	Level 2	Level 3	Total Fair Value
December 31, 2015				
Guaranteed investment contract	$ –	$ –	$ 899	$ 899
Total assets in the fair value hierarchy	–	–	$ 899	899
Investments measured at net asset value				49,965
Investments at fair value				$ 50,864

	Fair Value Measurements Using			
	Level 1	Level 2	Level 3	Total Fair Value
December 31, 2014				
Guaranteed investment contract	$ –	$ –	$ 1,080	$ 1,080
Total assets in the fair value hierarchy	–	–	$ 1,080	1,080
Investments measured at net asset value				52,201
Investments at fair value				$ 53,281

Guaranteed Investment Contract. The Plan is party to a contract with the John Hancock Life Insurance Company ("John Hancock") under which the Plan previously contributed a specified amount, and John Hancock maintains the contributions in an unallocated annuity fund to which the contributions earn interest at market rate. The balance in the fund is guaranteed never to be less than the aggregate contributions made to the accumulation fund, less all expenses, taxes, and amounts withdrawn to pay benefits. There are no guarantees as to the amount of interest.

12. Defined Benefit Pension Plan (continued)

Investments measured at net asset value. Net asset value per share is based on the fair value of the underlying investments within these pooled separate accounts consisting of common stock valued at the closing price reported on the active market on which the individual securities are traded, and corporate bonds, government bonds, collateralized mortgage obligations and other asset backed securities valued at the bid price or the average of the bid and ask price using pricing models, quoted prices of securities with similar characteristics, or broker quotes. Certain of these investments have redemption restrictions for 30 days, and the remainder of the investments do not have any redemption restrictions.

Plan Assets

The Company has adopted and implemented investment policies for the Plan that incorporate strategic asset allocation mixes intended to best meet the Plan's long-term obligations, while maintaining an appropriate level of risk and liquidity. The asset portfolio employs a diversified mix of investments, which are reviewed periodically. Active management strategies are utilized where feasible in an effort to realize investment returns in excess of market indices. The Plan's investment policies allow for investments in stable portfolios (consisting of short term, high quality debt securities), fixed income portfolios (primarily consisting of debt securities issued by the US government, foreign governments and US and foreign corporations), real assets (consisting largely of owned real estate and real estate investment trusts), US stocks and non-US stocks. The investment strategy currently targets a mix of 20-80% fixed income assets, 20-80% US equities, 0-25% foreign equities and 0-10% real assets.

13. Contingencies and Commitments

Litigation

The Company is subject to a variety of claims and suits that arise from time to time in the ordinary course of its business, acquisitions, or other transactions. While the Company's management currently believes that resolving all of these matters, individually or in the aggregate, will not have a material adverse impact on the Company's consolidated financial position or results of operations, the litigation and other claims that the Company faces are subject to inherent uncertainties and management's view of these matters may change in the future. Should an unfavorable final outcome occur, there exists the possibility of a material adverse impact on the Company's consolidated financial position, results of operations and cash flows for the period in which the effect becomes probable and reasonably estimable.

13. Contingencies and Commitments (continued)

On May 23, 2016, the United States Department of Justice ("USDOJ") filed a motion and notice of its intent to partially intervene in the False Claims Act ("FCA") action filed by a former employee of Alvarado Hospital. Pursuant to its notice, USDOJ is only intervening on the relator's FCA claim that California PHSI hospitals submitted claims for unnecessary inpatient admissions of patients who allegedly could have been treated on an outpatient basis, including through observation care. The USDOJ is not intervening on the relator's other FCA claims, including the allegation that PHSI hospitals submitted claims with false diagnoses of medical complications and comorbidities. While the Company has established a reserve of approximately $8.8 million, an estimate of the possible loss beyond amounts reserved cannot be made. There can be no assurance that the resolution of this investigation will not have a material adverse effect on the Company's financial position or results of operations.

In 2008, the Company sued Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and Southern California Permanente Medical Group (collectively, "Kaiser") seeking payment of underpaid or unpaid claims for healthcare services provided to Kaiser members. The Company contends that Kaiser has underpaid and failed to pay claims by improperly denying responsibility for payment under California law and paying for services at a rate that is less than the reasonable value of the services, in violation of law. Further lawsuits were filed and were coordinated as "add-on" cases in November 2011. In March 2014 the Company filed an amended complaint, narrowing the scope of the lawsuit. Kaiser responded by filing cross-complaints asserting claims against the Company. Kaiser asserted that the Company, among other things, improperly determined that patients were unstable for transfer, improperly coded the claims on the bills, and charged unreasonable amounts. Kaiser also alleged entitlement to reimbursement on some amounts it alleged were overpaid, but limited its claims to those in which the Company had claimed it was underpaid. On February 9, 2015, the Company and Kaiser agreed to dismiss their respective lawsuits against each other (Prime Healthcare Cases, Judicial Council Coordinated Proceedings No. 4580) and instead to resolve their disputes through confidential and binding arbitration. Binding arbitration is currently in process. The Company expects a decision in late 2016.

Legislation and HIPAA

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time. These laws and regulations include, but are not limited to, accreditation, licensure, government health care program participation requirements, reimbursement for patient services, and Medicare and

13. Contingencies and Commitments (continued)

Medicaid fraud and abuse. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in exclusion from government health care program participation, together with the imposition of significant fines and penalties, as well as significant repayment of past reimbursement received for patient services. While the Company is subject to similar regulatory review, management believes that the outcome of any potential regulatory review will not have a material adverse effect on the Company's consolidated financial position.

Management believes that the Company is in compliance with government laws and regulations related to fraud and abuse and other applicable areas. Compliance with such laws and regulations can be subject to future governmental review and interpretation, as well as regulatory actions unknown or unasserted at this time.

The Health Insurance Portability and Accountability Act ("HIPAA") assures health insurance portability, reduces healthcare fraud and abuse, guarantees security and privacy of health information, and enforces standards for health information. The Health Information Technology for Economic and Clinical Health Act expanded upon HIPAA in a number of ways, including establishing notification requirements for certain breaches of protected health information. In addition to these federal rules, California has also developed strict standards for the privacy and security of health information as well as for reporting certain violations and breaches. The Company may be subject to significant fines and penalties if found not to be compliant with these state or federal provisions.

Labor Relations

As of December 31, 2015, the Company had approximately 27,000 employees, of whom approximately 14% are represented by various labor organizations. Approximately 6% of the Company's employees are employed under union contracts that have expired or expire before December 31, 2016.

13. Contingencies and Commitments (continued)

The table below shows the Company's employees who are represented by unions:

Facility	Employee Group	Union	Date on Which Collective Bargaining Agreement Expires/Expired
Alvarado	Registered Nurses	CNA	December 31, 2015
Centinela	Registered Nurses	CNA	November 30, 2018
Centinela	Service, Maintenance, Technical, Skilled Maintenance and Business Office Clerical Employees	SEIU-UHW	December 31, 2009
Garden Grove	Registered Nurses	UNAC	September 30, 2016
Garden Grove	Professional Employees	SEIU-UHW	March 31, 2011
Garden Grove	Service, Maintenance, Technical and Skilled Maintenance Employees	SEIU-UHW	March 31, 2011
Landmark	EVS Employees	UFCW Local 328	February 28, 2017
Landmark	Certified Nursing Assistants	UNAP Local 5067	December 31, 2018
Landmark	Non-Professional Employees	UNAP Local 5067	December 31, 2018
Landmark	Professional Employees	UNAP Local 5067	December 31, 2018
Landmark	Technical Employees	UNAP Local 5067	December 31, 2018
Lower Bucks Hospital	Engineers and Maintenance	IUOE Local 835	September 19, 2014
Lower Bucks Hospital	Registered Nurses	PASNAP	December 31, 2019
St. Joseph Medical Center	Engineers and Maintenance Employees	IUOE Local 101S	March 31, 2018
Saint Mary's Regional Medical Center – Reno	Registered Nurses	CNA/NNU	March 31, 2016
Saint Mary's Regional Medical Center – Reno	Service Employees	CWA	September 30, 2016
Saint Mary's Regional Medical Center – Reno	Technical Employees	CWA	September 30, 2016
St. Mary's Hospital – Passaic	Skilled Maintenance Employees	IUOE Local 68-68A-68B	August 14, 2017
St. Mary's Hospital – Passaic	Registered Nurses	JNESO	August 14, 2017
St. Mary's Hospital – Passaic	Technical Employees	JNESO	August 14, 2017

For the expired contracts at Alvarado and Saint Mary's Regional Medical Center – Reno, tentative agreements were reached in April 2016 and the contracts are pending ratification.

13. Contingencies and Commitments (continued)

The following summarizes the status of the other collective bargaining agreements which have expired:

The Centinela collective bargaining agreement with SEIU–UHW terminated on December 31, 2009, and efforts to negotiate the terms of a new collective bargaining agreement have been unsuccessful to date. Subject to certain exceptions, the terms and conditions of employment as of the date on which the collective bargaining agreement terminated remain in place until such time that a new agreement is reached.

The Garden Grove collective bargaining agreement with SEIU–UHW terminated on March 31, 2011. Subject to certain exceptions, the terms and conditions of employment as of the date on which the collective bargaining agreement with SEIU terminated remain in place until such time that a new agreement is reached.

The Lower Bucks Hospital collective bargaining agreement with IUOE Local 835 expired on September 19, 2014. Subject to certain exceptions, the terms and conditions of employment as of the date on which the collective bargaining agreement terminated remain in place until such time that a new agreement is reached.

Provider Contracts

Many of the Company's payer and provider contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of medical services. Such differing interpretations may not come to light until a substantial period of time has passed following contract implementation. Liabilities for claims disputes are recorded when the loss is probable and can be estimated. Any adjustments to reserves are reflected in current operations.

13. Contingencies and Commitments (continued)

Capital Commitments

In connection with the acquisitions of various hospitals, such acquisition agreements require the Company to make certain capital expenditures before a specified date, such as facility renovations, medical equipment and information systems. The table below discloses such capital commitments over time (in thousands) as of December 31, 2015:

Years ending December 31:	
2016	$ 5,992
2017	–
2018	39,751
2019	6,817
2020	81,613
Total minimum commitments	$ 134,173

14. Subsequent Events

Subsequent events are events or transactions that occur after the consolidated balance sheet date but before consolidated financial statements are available to be issued. The Company recognizes in the consolidated financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the consolidated balance sheet, including the estimates inherent in the process of preparing the consolidated financial statements. The Company's consolidated financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the consolidated balance sheet but arose after the consolidated balance sheet date and before consolidated financial statements are available to be issued. The Company has evaluated subsequent events through May 31, 2016, which is the date the consolidated financial statements were available to be issued.

Financing

On January 26, 2016, the Company closed a $700 million senior secured credit facility (the "Facility") lead jointly by Wells Fargo Bank, N.A. and Barclays Bank, PLC. Of the $700 million, $400 million is a revolving facility, $200 million is a term loan and $100 million is an accordion feature. The Facility replaced the facility with HFG and matures on January 26, 2022. The term loan requires payments of $5 million from April 1, 2016 and continuing on a quarterly basis, with

14. Subsequent Events (continued)

the remaining outstanding balance due at maturity. The Facility bears interest at either LIBOR rate plus a margin, or the Base Rate, which is the greater of (a) the Federal Funds Rate plus 0.5%; (b) the LIBOR Rate plus 1%; or (c) the rate of interest announced by Wells Fargo as its "prime rate," plus a margin. The margins vary from 1% to 3% and are based upon the amount which has been borrowed under the revolving facility as compared to the amount that is currently available, based on a formula. The Facility requires the Company to maintain certain financial and non-financial covenants. The Company recognized a loss on extinguishment of the HFG facility of approximately $9.4 million in January 2016, representing the write off of unamortized loan costs.

Acquisitions

In September 2015, the Company entered into an asset purchase agreement with Community Health Systems, Inc. to acquire certain assets and liabilities of Lehigh Regional Medical Center, an 88 bed hospital located in Lehigh Acres, Florida. The purchase price was $11 million. The transaction closed on February 1, 2016. The purchase price allocation has not yet been completed.

In February 2013, the Company entered into an asset purchase agreement with Trinity Health to acquire certain assets and liabilities of St. Michael's Medical Center, a 357 bed hospital located in Newark, New Jersey. On August 10, 2015, the medical center voluntarily filed for Reorganization under Chapter 11 of the United States Bankruptcy Code. The United States Bankruptcy Court approved the transaction on November 12, 2015, the Attorney General of New Jersey approved the sale on March 9, 2016 and on April 7, 2016, and the final approval for the sale was received from the Superior Court. The purchase price was $62 million and the transaction closed on May 2, 2016. As part of the transaction, the Company has committed to capital expenditures of $25 million over five years. In connection with the acquisition, the Company entered into a master lease agreement with MPT. The purchase price allocation has not yet been completed.

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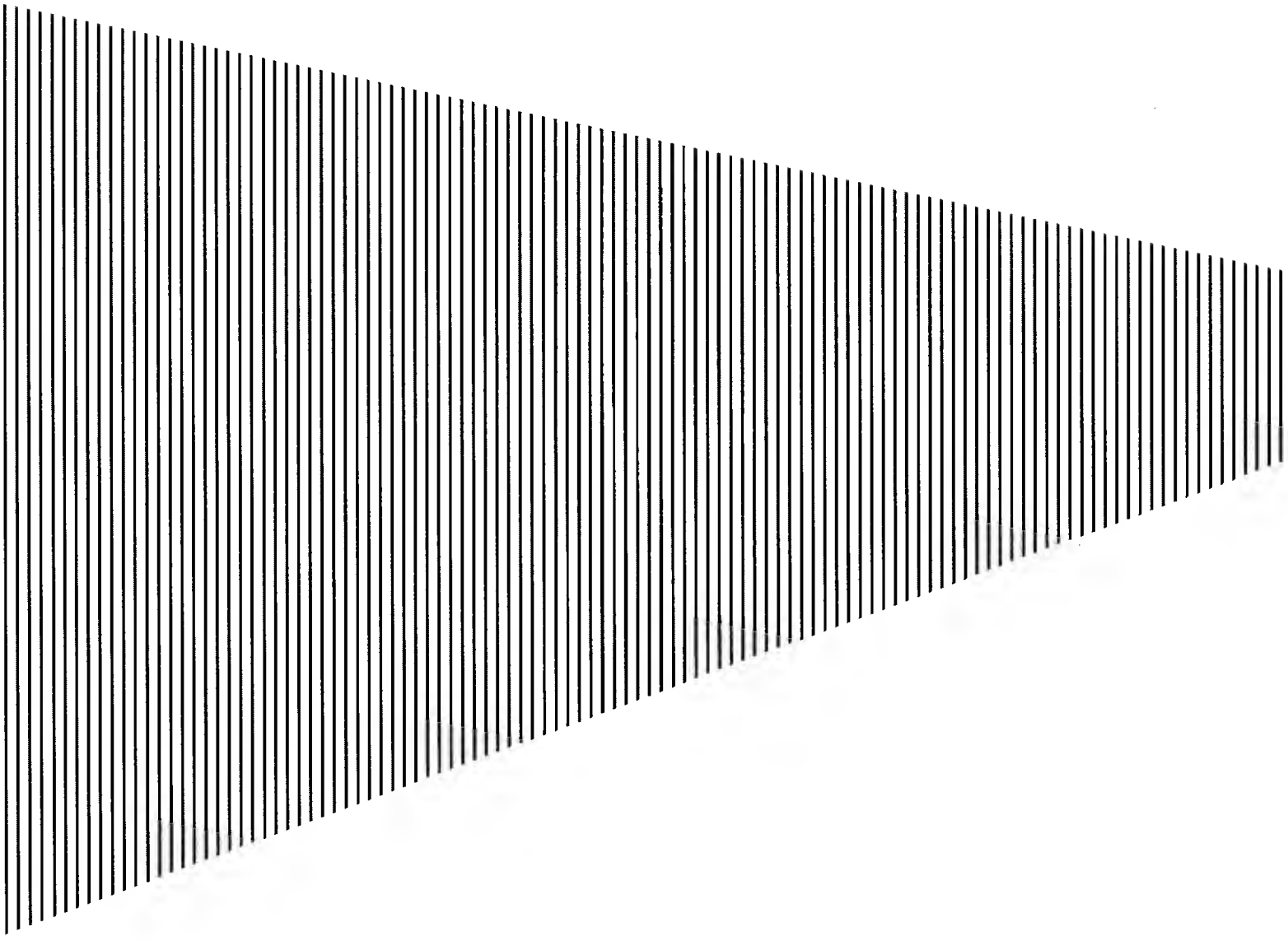

LANDMARK MEDICAL CENTER & AFFILIATES

FINANCIAL STATEMENTS

December 2016

LANDMARK MEDICAL CENTER
December 2016

	CURRENT MONTH OF DECEMBER 2016 (000)				DECEMBER 2016 YTD (000)			
	Actual	Prior Yr.	Variance	%	Actual	Prior Yr.	Variance	%
Net Revenue & Other Operating Income	10,456	11,062	(606)	-5.5%	121,921	122,883	(962)	-0.8%
Expenses (excluding Depreciation & Interest).	9,926	11,071	(1,145)	-10.3%	110,430	113,780	(3,350)	-2.9%
EBITDA before Management Fee	**530**	**(9)**	**540**	**-5795.9%**	**11,491**	**9,103**	**2,388**	**26.2%**
LMC Management Fee	608	1,259	(651)		7,083	6,992	91	
EBITDA after Management Fee	(78)	(1,268)	1,190	-93.8%	4,408	2,111	2,297	108.8%
Depreciation & Interest	405	343	62	17.9%	4,540	3,452	1,088	31.5%
Net Operating Profit/ (Loss)	(483)	(1,612)	1,129	-70.0%	(132)	(1,341)	1,209	-90.1%
Non-Operating Gain or Loss	10	77	(68)	-87.6%	126	28	97	345.5%
Pre Tax Income	(493)	(1,689)	1,197	-70.8%	(258)	(1,369)	1,111	-81.2%
Income Tax Expense	-	-	-	0.0%	-	-	-	0.0%
Net Income/(Loss) Before Extraordinary Items	(493)	(1,689)	1,197	-70.8%	(258)	(1,369)	1,111	-81.2%
Total Extraordinary Items	-	-	-	0.0%	-	-	-	0.0%
Total change in Net Assets	(493)	(1,689)	1,197	-70.8%	(258)	(1,369)	1,111	-81.2%
GPSR - Inpatient	25,432	17,536	7,896	45.0%	234,766	245,329	(10,563)	-4.3%
Outpatient	26,875	22,432	4,443	19.8%	285,070	260,286	24,784	9.5%
Total	52,307	39,968	12,338	30.9%	519,835	505,615	14,221	2.8%

LANDMARK MEDICAL CENTER and AFFILIATES
NET INCOME SUMMARY
December 2016

	CURRENT MONTH				YEAR TO DATE			
	LMC	RHRI	LPOS	Total	LMC	RHRI	LPOS	Total
Total Net Revenue	10,455,942	736,299	420,925	11,613,166	121,920,679	8,746,777	3,237,154	133,904,610
EBIDTAM	530,272	38,643	(416,313)	152,602	11,490,938	(459,676)	(5,037,139)	5,994,122
Management Fee	(608,452)	0	0	(608,452)	(7,082,750)	0	0	(7,082,750)
EBITDA	(78,180)	38,643	(416,313)	(455,850)	4,408,188	(459,676)	(5,037,139)	(1,088,628)
Depreciation,Interest, Non Op Rev,Exp	(414,393)	(6,272)	(3,950)	(424,615)	(4,666,124)	(54,112)	(43,250)	(4,763,486)
Net Income	(492,573)	32,371	(420,263)	(880,465)	(257,937)	(513,788)	(5,080,389)	(5,852,114)
EBIDTAM %	5.1%	5.2%	-98.9%	1.3%	9.4%	-5.3%	-155.6%	4.5%
EBITDA %	-0.7%	5.2%	-98.9%	-3.9%	3.6%	-5.3%	-155.6%	-0.8%
Net Income %	-4.7%	4.4%	-99.8%	-7.6%	-0.2%	-5.9%	-156.9%	-4.4%

REHABILITATION HOSPITAL OF RHODE ISLAND
STATEMENT OF ACTIVITIES
FOR THE TWELVE MONTH PERIOD ENDING DECEMBER 31, 2016

	<--------DECEMBER---------->				<----------YEAR TO DATE---------->			
	ACTUAL	Prior Yr.	VARIANCE	% VARIANCE	ACTUAL	Prior Yr.	VARIANCE	% VARIANCE
REVENUE								
GRDSS INPATIENT ROUTINE REVENUE	710,640	644,490	66,150	10.3%	8,070,300	8,408,610	(338,310)	(4.0%)
GROSS INPATIENT ANCILLARY REVENUE	950,743	793,712	157,030	19.8%	10,534,925	10,338,169	196,756	1.9%
TOTAL INPATIENT GROSS REVENUE	1,661,383	1,438,202	223,180	15.5%	18,605,225	18,746,779	(141,554)	(0.8%)
GROSS OUTPATIENT ANCILLARY REVENUE	587,975	1,152,284	(564,309)	(49.0%)	10,948,096	12,342,867	(1,394,771)	(11.3%)
TOTAL GROSS PATIENT REVENUE	2,249,358	2,590,487	(341,128)	(13.2%)	29,553,320	31,089,646	(1,536,326)	(4.9%)
TOTAL DEDUCTIONS	(1,556,838)	(1,774,159)	217,322	12.2%	(21,370,529)	(21,979,084)	608,555	2.8%
TDTAL NET PATIENT REVENUE	692,521	816,327	(123,807)	(15.2%)	8,182,791	9,110,562	(927,771)	(10.2%)
OTHER OPERATING REVENUE	43,779	58,588	(14,810)	(25.3%)	563,986	602,385	(38,400)	(6.4%)
TOTAL NET REVENUE	736,299	874,916	(138,617)	(15.8%)	8,746,777	9,712,947	(966,170)	(9.9%)
EXPENSE								
SALARIES AND WAGES	346,192	409,754	(63,563)	(15.5%)	4,414,538	4,747,184	(332,646)	(7.0%)
BENEFITS	80,338	86,795	(6,457)	(7.4%)	1,005,546	860,212	145,334	16.9%
PAYROLL TAXES	34,604	29,283	5,320	18.2%	420,971	405,588	15,383	3.8%
PAID TIME OFF	43,408	(2,030)	45,438	2238.8%	333,267	61,430	271,837	442.5%
CONTRACT LABOR								
REGISTRY	583	5	578	11555.0%	58,063	5,285	52,778	998.6%
DTHER MEDICAL	0	38,190	(38,190)	(100.0%)	136,656	230,300	(93,644)	(40.7%)
DTHER CONTRACT LABOR	0	0	0	0.0%	0	0	0	0.0%
LABDR SUBTOTAL	505,124	561,998	(56,874)	(10.1%)	6,369,041	6,309,999	59,042	0.9%
SUPPLIES BILLABLE	(2,071)	17,619	(19,690)	(111.8%)	215,908	86,875	129,033	148.5%
SUPPLIES NON BILLABLE	18,613	9,016	9,597	106.4%	105,917	101,827	4,091	4.0%
PURCHASED SERVICES	60,877	98,303	(37,426)	(38.1%)	1,066,042	1,243,572	(177,530)	(14.3%)
PROFESSIONAL FEES	(22,072)	53,852	(75,924)	(141.0%)	94,615	167,615	(73,000)	(43.6%)
MANAGED CARE FEES	0	0	0	0.0%	0	0	0	0.0%
REPAIRS AND MAINTENANCE FEES	4,068	3,244	824	25.4%	35,425	56,053	(20,629)	(36.8%)
RENTS AND LEASES	54,283	60,444	(6,160)	(10.2%)	650,981	707,027	(56,046)	(7.9%)
INSURANCE	14,829	11,667	3,162	27.1%	198,421	131,432	66,989	51.0%
UTILITIES	21,860	14,874	6,987	47.0%	207,834	202,263	5,571	2.8%
TAXES AND LICENSES	15,092	12,982	2,110	16.3%	139,040	172,322	(33,282)	(19.3%)
OTHER OPERATING EXPENSES	27,052	17,696	9,356	52.9%	123,230	68,332	54,898	80.3%
MANAGEMENT FEES	0	0	0	0.0%	0	0	0	0.0%
TOTAL OPERATING EXPENSES	697,656	861,695	(164,039)	(19.0%)	9,206,453	9,247,317	(40,863)	(0.4%)
EBITDA	38,643	13,221	25,422	192.3%	(459,676)	465,631	(925,307)	(198.7%)
DEPRECIATION	7,918	7,189	729	10.1%	82,752	79,575	3,177	4.0%
INTEREST INCOME	(186)	(174)	(12)	(7.2%)	(2,736)	(1,234)	(1,503)	(121.8%)
INTEREST EXPENSE	449	343	106	30.8%	3,390	7,342	(3,952)	(53.8%)
OTHER NON OPERATING	(1,908)	(3,229)	1,321	40.9%	(29,294)	(34,149)	4,855	14.2%
(GAIN)/ LOSS ON ASSET SALES	0	0	0	0.0%	0	3,312	(3,312)	(100.0%)
TOTAL NON OPERATING EXPENSES	6,272	4,129	2,143	51.9%	54,112	54,846	(734)	(1.3%)
PRETAX INCDME	32,371	9,092	23,279	256.0%	(513,788)	410,785	(924,573)	(225.1%)
INCOME TAX EXPENSE	0	0	0	0.0%	0	0	0	0.0%
NET INCOME / (LOSS) BEFORE EXTRA ITEMS	32,371	9,092	23,279	256.0%	(513,788)	410,785	(924,573)	(225.1%)
TDTAL EXTRAORDINARY ITEMS	0	0	0	0.0%	0	0	0	0.0%

NET INCOME (LOSS)	32,371	9,092	23,279	256.0%	(513,788)	410,785	(924,573)	(225.1%)

LANDMARK MEDICAL CENTER & REHABILITATION HOSPITAL OF RI
December 2016

	CURRENT MONTH				YEAR TO DATE			
	Actual	Prior Yr.	Variance	%	Actual	Prior Yr.	Variance	%
LANDMARK MEDICAL CENTER:								
Inpatient Acute Discharges w/o OB or Nbn	505	436	69	16%	5,522	5,938	(416)	-7%
Inpatient Acute Discharges OB	43	15	28	187%	293	214	79	37%
Inpatient Psych Discharges	37	54	(17)	-31%	492	444	48	11%
Total Inpatient Discharges w/o Nbn	585	505	80	16%	6,307	6,596	(289)	-4%
Inpatient Newborn Discharges	39	11	28	255%	267	179	88	49%
Inpatient Acute Days w/o Nbn	1,947	1,727	220	13%	21,321	26,968	(201)	-1%
Inpatient Psych Days	280	348	(68)	-20%	3,661	3,844	(183)	-5%
Total Inpatient Days w/o Nbn	2,227	2,075	152	7%	24,982	30,812	(384)	-1%
Inpatient Newborn Days	93	26	67	258%	638	448	190	42%
Case Mix Index - All Discharges(except Medicaid & UHP Rite Care) (	1.4355	1.3958	0.0399	3%	1.4482	1.0480	0.4002	38%
Case Mix Index - Medicare & Managed Medicare Discharges (1)	1.6727	1.4018	0.2709	19%	1.5414	1.4523	0.0891	6%
ALOS: Without Psychiatry	3.6	3.8	-0.2	-5%	3.7	4.4	(0.7)	-16%
ALOS: Psychiatry	7.6	8.4	1.2	19%	7.4	8.7	(1.3)	-15%
Inpatient Ancillary:								
Cath Lab (Cases) (2)	73	67	6	9%	757	689	68	10%
Surgery (Cases)	65	94	(29)	-31%	1,040	1,291	(251)	-19%
Laboratory (Tests)	17,546	14,040	3,506	25%	188,068	219,801	(33,733)	-15%
MRI (Procedures)	23	26	(3)	-12%	248	273	(27)	-10%
CT Scans (Procedures)	314	215	99	48%	3,255	3,176	79	2%
Outpatient:								
Cath Lab (Cases) (2)	46	26	20	77%	484	493	(9)	-2%
Total Ambulatory Surgery (Cases)	281	398	(117)	-29%	3,996	3,998	(2)	0%
Oncology (treatments)	252	168	84	50%	1,728	1,963	(235)	-12%
Infusion (treatments)	-	103	(103)	-100%	899	1,185	(286)	-24%
Total Oncology/Infusion (treatments)	252	271	(19)	-7%	2,627	3,148	(521)	-17%
Laboratory (Tests)	14,988	19,436	(4,448)	-23%	227,180	226,938	242	0%
Radiology (Procedures)	4,783	5,077	(314)	-6%	59,779	59,308	471	1%
							-	0%
Diagnostic Svs (Tests)	697	1,472	(775)	-53%	15,342	16,579	(1,237)	-7%
Observation (Cases) (3)	117	87	30	34%	875	767	108	14%
Sleep Studies (Procedures)	16	17	(1)	-6%	290	160	130	81%
Outpatient Cases, treatments etc from above	21,160	26,784	(5,624)	-21%	310,573	311,391	(818)	0%
Outpatient Visits (total patients)	9,231	8,611	620	7%	105,421	104,549	872	1%
IP Emergency Room (Visits)	512	490	22	4%	5,693	5,701	(8)	0%
OP Emergency Room (Visits)	2,629	2,951	(322)	-11%	33,409	33,202	207	1%
TOT Emergency Room (Visits)	3,141	3,441	(300)	-9%	39,102	38,903	199	1%
% Inpatient Emergency Room Visits to Total	16.3%	14.2%	0	14%	14.6%	14.7%	0%	-1%

LANDMARK MEDICAL CENTER & REHABILITATION HOSPITAL OF RI
December 2016

	CURRENT MONTH				YEAR TO DATE							
	Actual	Prior Yr.	Variance	%	Actual	Prior Yr.	Variance	%				
REHABILITATION HOSPITAL OF RHODE ISLAND:												
Inpatient Discharges	34	32	2	6%	340	360	(20)	-6%				
Inpatient Days	376	341	35	10%	4,270	4,450	(180)	-4%				
Average Daily Census	12.1	11.0	1.1	10%	11.7	2.0	9.7	485%				
Outpatient:												
Physical Therapy	1,100	1,999	(899)	-45%	19,099	21,483	(2,384)	-11%	19,099	21,483	-	-
Occupational Therapy	324	468	(144)	-31%	4,990	5,501	(511)	-9%	4,990	5,501	-	-
Speech Therapy	16	27	(11)	-41%	618	301	317	105%	618	301	-	-
Total Outpatient Therapy	1,440	2,494	(1,054)	-42%	24,707	27,285	(2,578)	-9%	24,707	27,285	-	-

(1) - Case Mix indices using Medicare Grouper excluding Psych and Newborn.
(2) - Includes Diagnostic Cath, Interventional Cath Procedures, PCI, and PTA Peripherals
(3) - Changed statistic to Cases from Days

LANDMARK MEDICAL CENTER and AFFILIATES
SUMMARY STATEMENT
FOR THE MONTH OF DECEMBER 2016
CONSOLIDATED

	Landmark Medical Center	LPOS	Landmark Medical Center w/LPOS	RHRI	Landmark Medical Center w/LPOS & RHRI
REVENUE					
GROSS INPATIENT ROUTINE REVENUE	6,804,510	-	6,804,510	710,640	7,515,150
GROSS INPATIENT ANCILLARY REVENUE	18,626,994	525,191	19,152,186	950,743	20,102,929
TOTAL INPATIENT GROSS REVENUE	25,431,504	525,191	25,956,696	1,661,383	27,618,079
	-	-		0	0
GROSS OUTPATIENT ANCILLARY REVENUE	26,875,174	520,906	27,398,080	587,975	27,984,056
TOTAL GROSS PATIENT REVENUE	52,306,679	1,046,097	53,352,778	2,249,358	55,602,134
	-	-		0	0
TOTAL DEDUCTIONS	(42,185,814)	(625,172)	(42,790,988)	(1,558,838)	(44,347,824)
	-	-		0	0
TOTAL NET PATIENT REVENUE	10,140,884	420,926	10,561,790	692,521	11,254,310
	-	-		0	0
OTHER OPERATING REVENUE	315,078	(1)	315,077	43,779	358,858
	-	-		0	0
TOTAL NET REVENUE	10,455,942	420,925	10,876,867	736,299	11,813,166
	-	-		0	0
EXPENSE	-	-		0	0
SALARIES AND WAGES	3,345,320	504,896	3,850,216	346,192	4,196,408
BENEFITS	830,812	49,069	879,881	80,338	960,219
PAYROLL TAXES	290,131	34,054	324,186	34,604	358,789
PAID TIME OFF	371,914	36,027	407,941	43,408	451,349
CONTRACT LABOR					
REGISTRY	-	-	0	583	583
OTHER MEDICAL	-	-	0	0	0
OTHER CONTRACT LABOR	-	-	0	0	0
LABOR SUBTOTAL	4,838,177	624,046	5,462,224	505,124	5,967,348
	-	-		0	0
SUPPLIES BILLABLE	1,470,602	38,791	1,509,393	(2,071)	1,507,323
SUPPLIES NON BILLABLE	318,986	22,500	341,486	18,613	360,099
PURCHASED SERVICES	2,237,457	75,720	2,313,177	60,877	2,374,054
PROFESSIONAL FEES	2,960	-	2,960	(22,072)	(19,112)
MANAGED CARE FEES	-	-	0	0	0
REPAIRS AND MAINTENANCE FEES	14,159	-	14,159	4,068	18,227
RENTS AND LEASES	143,389	37,924	181,313	54,283	235,597
INSURANCE	82,503	21,436	103,939	14,829	118,768
UTILITIES	110,329	4,626	114,955	21,860	136,815
TAXES AND LICENSES	613,551	-	613,551	15,092	628,643
OTHER OPERATING EXPENSES	93,557	12,194	105,751	27,052	132,803
MANAGEMENT FEES	608,452	-	608,452	0	608,452
	-	-		0	0
TOTAL OPERATING EXPENSES	10,534,122	837,238	11,371,360	697,656	12,069,016
EBITDA	(78,180)	(416,313)	(494,493)	38,643	(455,850)
DEPRECIATION	384,259	4,030	388,289	7,918	396,207
INTEREST INCOME	(4)	-	(4)	(186)	(190)
INTEREST EXPENSE	20,520	(79)	20,440	449	20,889
OTHER NON OPERATING	9,618	-	9,618	(1,908)	7,710
(GAIN)/ LOSS ON ASSET SALES	-	-	0	0	0
TOTAL NON OPERATING EXPENSES	414,393	3,950	418,343	6,272	424,615
PRETAX INCOME	(492,573)	(420,263)	(912,836)	32,371	(880,465)
INCOME TAX EXPENSE	-	-	0	0	0
NET INCOME / (LOSS) BEFORE EXTRA ITEMS	(492,573)	(420,263)	(912,838)	32,371	(880,465)
					0
TOTAL EXTRAORDINARY ITEMS	-	-	0	0	0
	-	-	0	0	0
NET INCOME (LOSS)	(492,673)	(420,263)	(912,836)	32,371	(880,465)

LANDMARK MEDICAL CENTER and AFFILIATES
SUMMARY STATEMENT
FOR THE TWELVE MONTH PERIOD ENDING DECEMBER 31, 2016
CONSOLIDATED

	Landmark Medical Center	LPOS	Landmark Medical Center w/LPOS	RHRI	Landmark Medical Center w/LPOS & RHRI
REVENUE					
GROSS INPATIENT ROUTINE REVENUE	73,461,149	(13)	73,461,136	8,070,300	81,531,436
GROSS INPATIENT ANCILLARY REVENUE	161,304,596	4,968,822	166,273,418	10,534,925	176,808,343
TOTAL INPATIENT GROSS REVENUE	234,765,745	4,968,809	239,734,554	18,605,225	258,339,779
			0		0
GROSS OUTPATIENT ANCILLARY REVENUE	285,069,560	4,144,500	289,214,060	10,948,096	300,162,155
TOTAL GROSS PATIENT REVENUE	519,835,305	9,113,309	528,948,614	29,553,320	558,501,935
TOTAL DEDUCTIONS	(401,674,747)	(5,959,082)	(407,833,830)	(21,370,529)	(429,004,359)
TOTAL NET PATIENT REVENUE	118,160,557	3,154,227	121,314,784	8,182,791	129,497,578
OTHER OPERATING REVENUE	3,760,121	82,927	3,843,048	563,986	4,407,034
TOTAL NET REVENUE	121,920,679	3,237,154	125,157,833	8,746,777	133,904,610
EXPENSE					
SALARIES AND WAGES	45,047,690	3,346,346	48,394,035	4,414,538	52,808,573
BENEFITS	10,724,367	349,227	11,073,594	1,005,546	12,079,140
PAYROLL TAXES	4,283,424	194,203	4,477,627	420,971	4,898,598
PAID TIME OFF	3,349,869	317,192	3,667,061	333,267	4,000,329
CONTRACT LABOR					
REGISTRY	58,606	0	58,606	58,063	116,669
OTHER MEDICAL	0	0	0	136,656	136,656
OTHER CONTRACT LABOR	0	0	0	0	0
LABOR SUBTOTAL	63,463,956	4,206,967	67,670,923	6,369,041	74,039,964
SUPPLIES BILLABLE	16,955,991	288,187	17,244,178	215,908	17,460,086
SUPPLIES NON BILLABLE	3,324,083	72,554	3,396,637	105,917	3,502,555
PURCHASED SERVICES	12,432,672	2,832,880	15,265,552	1,066,042	16,331,594
PROFESSIONAL FEES	1,127,360	0	1,127,360	94,615	1,221,975
MANAGED CARE FEES	0	0	0	0	0
REPAIRS AND MAINTENANCE FEES	373,232	0	373,232	35,425	408,657
RENTS AND LEASES	1,298,578	470,659	1,769,238	650,981	2,420,218
INSURANCE	1,056,994	252,305	1,309,299	198,421	1,507,720
UTILITIES	1,693,288	50,253	1,743,540	207,834	1,951,374
TAXES AND LICENSES	7,337,332	86	7,337,419	139,040	7,476,459
OTHER OPERATING EXPENSES	1,366,255	100,401	1,466,655	123,230	1,589,886
MANAGEMENT FEES	7,082,750	0	7,082,750	0	7,082,750
TOTAL OPERATING EXPENSES	117,512,491	8,274,293	125,786,784	9,206,453	134,993,237
EBITDA	4,408,188	(5,037,139)	(628,952)	(459,676)	(1,088,628)
DEPRECIATION	4,170,132	42,679	4,212,810	82,752	4,295,563
INTEREST INCOME	(6,633)	0	(6,633)	(2,736)	(9,370)
INTEREST EXPENSE	370,275	572	370,847	3,390	374,237
OTHER NON OPERATING	134,311	0	134,311	(29,294)	105,017
(GAIN)/ LOSS ON ASSET SALES	(1,960)	0	(1,960)	0	(1,960)
TOTAL NON OPERATING EXPENSES	4,666,124	43,250	4,709,375	54,112	4,763,486
PRETAX INCOME	(257,937)	(5,080,389)	(5,338,326)	(513,788)	(5,852,114)
INCOME TAX EXPENSE	0	0	0	0	0
NET INCOME / (LOSS) BEFORE EXTRA ITEMS	(257,937)	(5,080,389)	(5,338,328)	(513,788)	(5,852,114)
TOTAL EXTRAORDINARY ITEMS	0	0	0	0	0
					0
NET INCOME (LOSS)	(257,937)	(5,080,389)	(5,338,326)	(513,788)	(5,852,114)

LANDMARK MEDICAL CENTER
STATEMENT OF ACTIVITIES
FOR THE TWELVE MONTH PERIOD ENDING DECEMBER 31, 2016

	<-------DECEMBER---------->				<----------YEAR TO DATE---------->			
	ACTUAL	Prior Yr.	VARIANCE	% VARIANCE	ACTUAL	Prior Yr.	VARIANCE	% VARIANCE
REVENUE								
GROSS INPATIENT ROUTINE REVENUE	6,804,510	5,841,205	963,305	16.5%	73,461,149	88,674,950	(15,213,801)	(17.2%)
GROSS INPATIENT ANCILLARY REVENUE	18,626,994	11,694,768	6,932,227	59.3%	161,304,596	156,653,761	4,650,836	3.0%
TOTAL INPATIENT GROSS REVENUE	25,431,504	17,535,973	7,895,532	45.0%	234,765,745	245,328,711	(10,562,966)	(4.3%)
GROSS OUTPATIENT ANCILLARY REVENUE	26,875,174	22,432,248	4,442,927	19.8%	285,069,560	260,286,036	24,783,523	9.5%
TOTAL GROSS PATIENT REVENUE	52,306,679	39,968,220	12,338,458	30.9%	519,835,305	505,614,747	14,220,558	2.8%
TOTAL DEDUCTIONS	(42,165,814)	(30,110,015)	(12,055,800)	(40.0%)	(401,674,747)	(389,084,457)	(12,590,290)	(3.2%)
TOTAL NET PATIENT REVENUE	10,140,864	9,858,206	282,659	2.9%	118,160,557	116,530,290	1,630,267	1.4%
OTHER OPERATING REVENUE	315,078	1,203,360	(888,282)	(73.8%)	3,760,121	6,352,598	(2,592,477)	(40.8%)
TOTAL NET REVENUE	10,455,942	11,061,565	(605,623)	(5.5%)	121,920,679	122,882,888	(962,209)	(0.8%)
EXPENSE								
SALARIES AND WAGES	3,345,320	4,373,330	(1,028,010)	(23.5%)	45,047,690	50,160,075	(5,112,386)	(10.2%)
BENEFITS	830,812	1,785,634	(954,822)	(53.5%)	10,724,367	13,842,109	(3,117,741)	(22.5%)
PAYROLL TAXES	290,131	317,848	(27,716)	(8.7%)	4,283,424	4,448,295	(164,871)	(3.7%)
PAID TIME OFF	371,914	20,922	350,993	1677.6%	3,349,869	201,460	3,148,409	1562.8%
CONTRACT LABOR								
REGISTRY	0	29,362	(29,362)	(100.0%)	58,606	176,301	(117,695)	(66.8%)
OTHER MEDICAL	0	0	0	0.0%	0	0	0	0.0%
OTHER CONTRACT LABOR	0	0	0	0.0%	0	0	0	0.0%
LABOR SUBTOTAL	4,838,177	6,527,095	(1,688,918)	(25.9%)	63,463,956	68,828,240	(5,364,284)	(7.8%)
SUPPLIES BILLABLE	1,470,602	817,119	653,483	80.0%	16,955,991	16,693,931	262,060	1.6%
SUPPLIES NON BILLABLE	318,986	279,416	39,570	14.2%	3,324,083	2,785,528	538,555	19.3%
PURCHASED SERVICES	2,237,457	1,079,572	1,157,884	107.3%	12,432,672	11,000,614	1,432,058	13.0%
PROFESSIONAL FEES	2,960	252,040	(249,080)	(98.8%)	1,127,360	1,276,402	(149,042)	(11.7%)
MANAGED CARE FEES	0	0	0	0.0%	0	0	0	0.0%
REPAIRS AND MAINTENANCE FEES	14,159	27,817	(13,658)	(49.1%)	373,232	305,960	67,272	22.0%
RENTS AND LEASES	143,389	97,648	45,741	46.8%	1,298,578	1,033,230	265,348	25.7%
INSURANCE	82,503	1,029,172	(946,669)	(92.0%)	1,056,994	1,757,766	(700,772)	(39.9%)
UTILITIES	110,329	130,814	(20,485)	(15.7%)	1,693,288	1,963,912	(270,625)	(13.8%)
TAXES AND LICENSES	613,551	695,024	(81,473)	(11.7%)	7,337,332	6,931,542	405,791	5.9%
OTHER OPERATING EXPENSES	93,557	135,157	(41,600)	(30.8%)	1,366,255	1,202,786	163,469	13.6%
MANAGEMENT FEES	608,452	1,259,166	(650,714)	(51.7%)	7,082,750	6,991,817	90,933	1.3%
TOTAL OPERATING EXPENSES	10,534,122	12,330,041	(1,795,919)	(14.6%)	117,512,491	120,771,729	(3,259,238)	(2.7%)
EBITDA	(78,180)	(1,268,476)	1,190,296	93.8%	4,408,188	2,111,159	2,297,028	108.8%
DEPRECIATION	384,259	303,108	81,152	26.8%	4,170,132	3,142,853	1,027,279	32.7%
INTEREST INCOME	(4)	(734)	730	99.5%	(6,633)	(39,675)	33,042	83.3%
INTEREST EXPENSE	20,520	40,144	(19,624)	(48.9%)	370,275	309,501	60,774	19.6%
OTHER NON OPERATING	9,618	(7,398)	17,016	230.0%	134,311	(24,408)	158,719	650.3%
(GAIN)/ LOSS ON ASSET SALES	0	85,488	(85,488)	(100.0%)	(1,960)	92,303	(94,264)	(102.1%)
TOTAL NON OPERATING EXPENSES	414,393	420,608	(6,216)	(1.5%)	4,666,124	3,480,574	1,185,550	34.1%
PRETAX INCOME	(492,573)	(1,689,084)	1,196,511	70.8%	(257,937)	(1,369,415)	1,111,478	81.2%
INCOME TAX EXPENSE	0	0	0	0.0%	0	0	0	0.0%
NET INCOME / (LOSS) BEFORE EXTRA ITEMS	(492,573)	(1,689,084)	1,196,511	70.8%	(257,937)	(1,369,415)	1,111,478	81.2%
TOTAL EXTRAORDINARY ITEMS	0	0	0	0.0%	0	0	0	0.0%
NET INCOME (LOSS)	(492,573)	(1,689,084)	1,196,511	70.8%	(257,937)	(1,369,415)	1,111,478	81.2%

LPOS
STATEMENT OF ACTIVITIES
FOR THE TWELVE MONTH PERIOD ENDING DECEMBER 31, 2016

	<------DECEMBER---------->				<----------YEAR TO DATE---------->			
	ACTUAL	Prior Yr.	VARIANCE	% VARIANCE	ACTUAL	Prior Yr.	VARIANCE	% VARIANCE
REVENUE								
GROSS INPATIENT ROUTINE REVENUE	-	-	0	0.0%	(13)	-	(13)	0.0%
GROSS INPATIENT ANCILLARY REVENUE	525,191	275,131	250,060	90.9%	4,968,822	3,089,442	1,879,380	60.8%
TOTAL INPATIENT GROSS REVENUE	525,191	275,131	250,060	90.9%	4,968,809	3,089,442	1,879,367	60.8%
GROSS OUTPATIENT ANCILLARY REVENUE	520,906	316,061	204,844	64.8%	4,144,500	4,696,263	(551,763)	(11.7%)
TOTAL GROSS PATIENT REVENUE	1,046,097	591,193	454,905	76.9%	9,113,309	7,785,706	1,327,604	17.1%
TOTAL DEDUCTIONS	(625,172)	(360,167)	(265,004)	(73.6%)	(5,959,082)	(5,338,501)	(620,581)	(11.6%)
TOTAL NET PATIENT REVENUE	420,926	231,025	189,900	82.2%	3,154,227	2,447,204	707,022	28.9%
OTHER OPERATING REVENUE	(1)	10,165	(10,166)	(100.0%)	82,927	142,087	(59,160)	(41.6%)
TOTAL NET REVENUE	420,925	241,190	179,735	74.5%	3,237,154	2,589,292	647,862	25.0%
EXPENSE								
SALARIES AND WAGES	504,896	80	504,816	630704.7%	3,346,346	618	3,345,727	541143.4%
BENEFITS	49,069	0	49,069	0.0%	349,227	0	349,227	0.0%
PAYROLL TAXES	34,054	0	34,054	0.0%	194,203	0	194,203	0.0%
PAID TIME OFF	36,027	0	36,027	0.0%	317,192	0	317,192	0.0%
CONTRACT LABOR								
REGISTRY	0	0	0	0.0%	0	0	0	0.0%
OTHER MEDICAL	0	0	0	0.0%	0	0	0	0.0%
OTHER CONTRACT LABOR	0	0	0	0.0%	0	0	0	0.0%
LABOR SUBTOTAL	624,046	80	623,966	779568.2%	4,206,967	618	4,206,349	680341.8%
SUPPLIES BILLABLE	38,791	5,961	32,830	550.7%	288,187	124,798	163,389	130.9%
SUPPLIES NON BILLABLE	22,500	14,566	7,935	54.5%	72,554	53,470	19,085	35.7%
PURCHASED SERVICES	75,720	690,837	(615,117)	(89.0%)	2,832,880	5,466,876	(2,633,996)	(48.2%)
PROFESSIONAL FEES	0	0	0	0.0%	0	0	0	0.0%
MANAGED CARE FEES	0	0	0	0.0%	0	0	0	0.0%
REPAIRS AND MAINTENANCE FEES	0	0	0	0.0%	0	1,247	(1,247)	(100.0%)
RENTS AND LEASES	37,924	34,196	3,728	10.9%	470,659	387,280	83,380	21.5%
INSURANCE	21,436	8,091	13,345	164.9%	252,305	97,519	154,786	158.7%
UTILITIES	4,628	5,110	(484)	(9.5%)	50,253	44,443	5,810	13.1%
TAXES AND LICENSES	0	86	(86)	(100.0%)	86	1,422	(1,336)	(93.9%)
OTHER OPERATING EXPENSES	12,194	16,007	(3,813)	(23.8%)	100,401	184,449	(84,048)	(45.6%)
MANAGEMENT FEES	0	0	0	0.0%	0	0	0	0.0%
TOTAL OPERATING EXPENSES	837,238	774,933	62,305	8.0%	8,274,293	6,362,122	1,912,171	30.1%
EBITDA	(416,313)	(533,743)	117,430	22.0%	(5,037,139)	(3,772,830)	(1,264,309)	(33.5%)
DEPRECIATION	4,030	2,764	1,266	45.8%	42,679	26,335	16,344	62.1%
INTEREST INCOME	0	0	0	0.0%	0	0	0	0.0%
INTEREST EXPENSE	(79)	65	(144)	(222.6%)	572	812	(240)	(29.6%)
OTHER NON OPERATING	0	0	0	0.0%	0	0	0	0.0%
(GAIN)/ LOSS ON ASSET SALES	0	0	0	0.0%	0	0	0	0.0%
TOTAL NON OPERATING EXPENSES	3,950	2,829	1,122	39.7%	43,250	27,147	16,104	59.3%
PRETAX INCOME	(420,263)	(536,572)	116,308	21.7%	(5,080,389)	(3,799,977)	(1,280,413)	(33.7%)
INCOME TAX EXPENSE	0	0	0	0.0%	0	0	0	0.0%
NET INCOME / (LOSS) BEFORE EXTRA ITEMS	(420,263)	(536,572)	116,308	21.7%	(5,080,389)	(3,799,977)	(1,280,413)	(33.7%)
TOTAL EXTRAORDINARY ITEMS	0	0	0	0.0%	0	0	0	0.0%
NET INCOME (LOSS)	(420,263)	(536,572)	116,308	21.7%	(5,080,389)	(3,799,977)	(1,280,413)	(33.7%)

LANDMARK MEDICAL CENTER
STATEMENT OF ACTIVITIES
FOR THE TWELVE MONTH PERIOD ENDING DECEMBER 31, 2016
CONSOLIDATED WITH LPOS

	<-------DECEMBER---------->				<--------------YEAR TO DATE---------->			
	ACTUAL	Prior Yr.	VARIANCE	% VARIANCE	ACTUAL	Prior Yr.	VARIANCE	% VARIANCE
REVENUE								
GROSS INPATIENT ROUTINE REVENUE	6,804,510	5,841,205	963,305	16.5%	73,461,136	88,674,950	(15,213,814)	(17.2%)
GROSS INPATIENT ANCILLARY REVENUE	19,152,186	11,969,899	7,182,287	60.0%	166,273,418	159,743,203	6,530,215	4.1%
TOTAL INPATIENT GROSS REVENUE	25,956,696	17,811,104	8,145,592	45.7%	239,734,554	248,418,153	(8,683,599)	(3.5%)
GROSS OUTPATIENT ANCILLARY REVENUE	27,396,080	22,748,309	4,647,771	20.4%	289,214,060	264,982,300	24,231,760	9.1%
TOTAL GROSS PATIENT REVENUE	53,352,776	40,559,413	12,793,363	31.5%	528,948,614	513,400,453	15,548,161	3.0%
TOTAL DEDUCTIONS	(42,790,986)	(30,470,182)	(12,320,804)	(40.4%)	(407,633,830)	(394,422,958)	(13,210,872)	(3.3%)
TOTAL NET PATIENT REVENUE	10,561,790	10,089,231	472,559	4.7%	121,314,784	118,977,494	2,337,290	2.0%
OTHER OPERATING REVENUE	315,077	1,213,525	(898,448)	(74.0%)	3,843,048	6,494,685	(2,651,637)	(40.8%)
TOTAL NET REVENUE	10,876,867	11,302,755	(425,889)	(3.8%)	125,157,833	125,472,180	(314,347)	(0.3%)
EXPENSE								
SALARIES AND WAGES	3,850,216	4,373,410	(523,194)	(12.0%)	48,394,035	50,160,694	(1,766,658)	(3.5%)
BENEFITS	879,881	1,785,634	(905,753)	(50.7%)	11,073,594	13,842,109	(2,768,515)	(20.0%)
PAYROLL TAXES	324,186	317,848	6,338	2.0%	4,477,627	4,448,295	29,332	0.7%
PAID TIME OFF	407,941	20,922	387,019	1849.8%	3,667,061	201,460	3,465,601	1720.2%
CONTRACT LABOR								
REGISTRY	0	29,362	(29,362)	(100.0%)	58,606	176,301	(117,695)	(66.8%)
OTHER MEDICAL	0	0	0	0.0%	0	0	0	0.0%
OTHER CONTRACT LABOR	0	0	0	0.0%	0	0	0	0.0%
LABOR SUBTOTAL	5,462,224	6,527,175	(1,064,951)	(16.3%)	67,670,923	68,828,859	(1,157,935)	(1.7%)
SUPPLIES BILLABLE	1,509,393	823,081	686,313	83.4%	17,244,178	16,818,729	425,449	2.5%
SUPPLIES NON BILLABLE	341,486	293,982	47,504	16.2%	3,396,637	2,838,998	557,639	19.6%
PURCHASED SERVICES	2,313,177	1,770,409	542,768	30.7%	15,265,552	16,467,490	(1,201,938)	(7.3%)
PROFESSIONAL FEES	2,960	252,040	(249,080)	(98.8%)	1,127,360	1,276,402	(149,042)	(11.7%)
MANAGED CARE FEES	0	0	0	0.0%	0	0	0	0.0%
REPAIRS AND MAINTENANCE FEES	14,159	27,817	(13,658)	(49.1%)	373,232	307,207	66,025	21.5%
RENTS AND LEASES	181,313.31	131,844.21	49,469	37.5%	1,769,237.50	1,420,510.21	348,727	24.5%
INSURANCE	103,939	1,037,263	(933,324)	(90.0%)	1,309,299	1,855,285	(545,986)	(29.4%)
UTILITIES	114,955	135,924	(20,969)	(15.4%)	1,743,540	2,008,355	(264,815)	(13.2%)
TAXES AND LICENSES	613,551	695,111	(81,560)	(11.7%)	7,337,419	6,932,964	404,455	5.8%
OTHER OPERATING EXPENSES	105,751	151,164	(45,413)	(30.0%)	1,466,655	1,387,234	79,421	5.7%
MANAGEMENT FEES	608,452	1,259,166	(650,714)	(51.7%)	7,082,750	6,991,817	90,933	1.3%
TOTAL OPERATING EXPENSES	11,371,360	13,104,974	(1,733,615)	(13.2%)	125,786,784	127,133,850	(1,347,066)	(1.1%)
EBITDA	(494,493)	(1,802,219)	1,307,726	72.6%	(628,952)	(1,661,671)	1,032,719	62.1%
DEPRECIATION	388,289	305,872	82,417	26.9%	4,212,810	3,169,188	1,043,623	32.9%
INTEREST INCOME	(4)	(734)	730	99.5%	(6,633)	(39,675)	33,042	83.3%
INTEREST EXPENSE	20,440	40,208	(19,768)	(49.2%)	370,847	310,313	60,534	19.5%
OTHER NON OPERATING	9,618	(7,398)	17,016	230.0%	134,311	(24,408)	158,719	650.3%
(GAIN)/ LOSS ON ASSET SALES	0	85,488	(85,488)	(100.0%)	(1,960)	92,303	(94,264)	(102.1%)
TOTAL NON OPERATING EXPENSES	418,343	423,437	(5,094)	(1.2%)	4,709,375	3,507,721	1,201,654	34.3%
PRETAX INCOME	(912,836)	(2,225,656)	1,312,820	59.0%	(5,338,326)	(5,169,391)	(168,935)	(3.3%)
INCOME TAX EXPENSE	0	0	0	0.0%	0	0	0	0.0%
NET INCOME / (LOSS) BEFORE EXTRA ITEMS	(912,836)	(2,225,656)	1,312,820	59.0%	(5,338,326)	(5,169,391)	(168,935)	(3.3%)
TOTAL EXTRAORDINARY ITEMS	0	0	0	0.0%	0	0	0	0.0%
NET INCOME (LOSS)	(912,836)	(2,225,656)	1,312,820	59.0%	(5,338,326)	(5,169,391)	(168,935)	(3.3%)

REHABILITATION HOSPITAL OF RHODE ISLAND
STATEMENT OF ACTIVITIES
FOR THE TWELVE MONTH PERIOD ENDING DECEMBER 31, 2016

	<----DECEMBER---->				<----YEAR TO DATE---->			
	ACTUAL	Prior Yr.	VARIANCE	% VARIANCE	ACTUAL	Prior Yr.	VARIANCE	% VARIANCE
REVENUE								
GROSS INPATIENT ROUTINE REVENUE	710,640	644,490	66,150	10.3%	8,070,300	8,408,610	(338,310)	(4.0%)
GROSS INPATIENT ANCILLARY REVENUE	950,743	793,712	157,030	19.8%	10,534,925	10,338,169	196,756	1.9%
TOTAL INPATIENT GROSS REVENUE	1,661,383	1,438,202	223,180	15.5%	18,605,225	18,746,779	(141,554)	(0.8%)
GROSS OUTPATIENT ANCILLARY REVENUE	587,975	1,152,284	(564,309)	(49.0%)	10,948,096	12,342,867	(1,394,771)	(11.3%)
TOTAL GROSS PATIENT REVENUE	2,249,358	2,590,487	(341,128)	(13.2%)	29,553,320	31,089,646	(1,536,326)	(4.9%)
TOTAL DEDUCTIONS	(1,556,838)	(1,774,159)	217,322	12.2%	(21,370,529)	(21,979,084)	608,555	2.8%
TOTAL NET PATIENT REVENUE	692,521	816,327	(123,807)	(15.2%)	8,182,791	9,110,562	(927,771)	(10.2%)
OTHER OPERATING REVENUE	43,779	58,588	(14,810)	(25.3%)	563,986	602,385	(38,400)	(6.4%)
TOTAL NET REVENUE	736,299	874,916	(138,617)	(15.8%)	8,746,777	9,712,947	(966,170)	(9.9%)
EXPENSE								
SALARIES AND WAGES	346,192	409,754	(63,563)	(15.5%)	4,414,538	4,747,184	(332,646)	(7.0%)
BENEFITS	80,338	86,795	(6,457)	(7.4%)	1,005,546	860,212	145,334	16.9%
PAYROLL TAXES	34,604	29,283	5,320	18.2%	420,971	405,588	15,383	3.8%
PAID TIME OFF	43,408	(2,030)	45,438	2238.8%	333,267	61,430	271,837	442.5%
CONTRACT LABOR								
REGISTRY	583	5	578	11555.0%	58,063	5,285	52,778	998.6%
OTHER MEDICAL	0	38,190	(38,190)	(100.0%)	136,656	230,300	(93,644)	(40.7%)
OTHER CONTRACT LABOR	0	0	0	0.0%	0	0	0	0.0%
LABOR SUBTOTAL	505,124	561,998	(56,874)	(10.1%)	6,369,041	6,309,999	59,042	0.9%
SUPPLIES BILLABLE	(2,071)	17,519	(19,590)	(111.8%)	215,908	86,875	129,033	148.5%
SUPPLIES NON BILLABLE	18,613	9,016	9,597	106.4%	105,917	101,827	4,091	4.0%
PURCHASED SERVICES	60,877	98,303	(37,426)	(38.1%)	1,066,042	1,243,572	(177,530)	(14.3%)
PROFESSIONAL FEES	(22,072)	53,852	(75,924)	(141.0%)	94,615	167,615	(73,000)	(43.6%)
MANAGED CARE FEES	0	0	0	0.0%	0	0	0	0.0%
REPAIRS AND MAINTENANCE FEES	4,068	3,244	824	25.4%	35,425	56,053	(20,629)	(36.8%)
RENTS AND LEASES	54,283	60,444	(6,160)	(10.2%)	650,981	707,027	(56,046)	(7.9%)
INSURANCE	14,829	11,667	3,162	27.1%	198,421	131,432	66,989	51.0%
UTILITIES	21,860	14,874	6,987	47.0%	207,834	202,263	5,571	2.8%
TAXES AND LICENSES	15,092	12,982	2,110	16.3%	139,040	172,322	(33,282)	(19.3%)
OTHER OPERATING EXPENSES	27,052	17,696	9,356	52.9%	123,230	68,332	54,898	80.3%
MANAGEMENT FEES	0	0	0	0.0%	0	0	0	0.0%
TOTAL OPERATING EXPENSES	697,656	861,695	(164,039)	(19.0%)	9,206,453	9,247,317	(40,863)	(0.4%)
EBITDA	38,643	13,221	25,422	192.3%	(459,676)	465,631	(925,307)	(198.7%)
DEPRECIATION	7,918	7,189	729	10.1%	82,752	79,575	3,177	4.0%
INTEREST INCOME	(186)	(174)	(12)	(7.2%)	(2,736)	(1,234)	(1,503)	(121.8%)
INTEREST EXPENSE	449	343	106	30.8%	3,390	7,342	(3,952)	(53.8%)
OTHER NON OPERATING	(1,908)	(3,229)	1,321	40.9%	(29,294)	(34,149)	4,855	14.2%
(GAIN)/ LOSS ON ASSET SALES	0	0	0	0.0%	0	3,312	(3,312)	(100.0%)
TOTAL NON OPERATING EXPENSES	6,272	4,129	2,143	51.9%	54,112	54,848	(734)	(1.3%)
PRETAX INCOME	32,371	9,092	23,279	256.0%	(513,788)	410,785	(924,573)	(225.1%)
INCOME TAX EXPENSE	0	0	0	0.0%	0	0	0	0.0%
NET INCOME / (LOSS) BEFORE EXTRA ITEMS	32,371	9,092	23,279	256.0%	(513,788)	410,785	(924,573)	(225.1%)
TOTAL EXTRAORDINARY ITEMS	0	0	0	0.0%	0	0	0	0.0%
NET INCOME (LOSS)	32,371	9,092	23,279	256.0%	(513,788)	410,785	(924,573)	(225.1%)

LANDMARK MEDICAL CENTER
STATEMENT OF ACTIVITIES
FOR THE TWELVE MONTH PERIOD ENDING DECEMBER 31, 2016
CONSOLIDATED

	<-------DECEMBER---------->				<-------------YEAR TO DATE------------->			
	ACTUAL	Prior Yr.	VARIANCE	% VARIANCE	ACTUAL	Prior Yr.	VARIANCE	% VARIANCE
REVENUE								
GROSS INPATIENT ROUTINE REVENUE	7,515,150	6,485,695	1,029,455	15.9%	81,531,436	97,083,560	(15,552,124)	(16.0%)
GROSS INPATIENT ANCILLARY REVENUE	20,102,929	12,763,611	7,339,317	57.5%	176,808,343	170,081,372	6,726,971	4.0%
TOTAL INPATIENT GROSS REVENUE	27,618,079	19,249,306	8,368,772	43.5%	258,339,779	267,164,932	(8,825,153)	(3.3%)
GROSS OUTPATIENT ANCILLARY REVENUE	27,984,056	23,900,593	4,083,462	17.1%	300,162,155	277,325,167	22,836,989	8.2%
TOTAL GROSS PATIENT REVENUE	55,602,134	43,149,900	12,452,235	28.9%	558,501,935	544,490,099	14,011,835	2.6%
TOTAL DEDUCTIONS	(44,347,824)	(32,244,341)	(12,103,482)	(37.5%)	(429,004,359)	(416,402,043)	(12,602,316)	(3.0%)
TOTAL NET PATIENT REVENUE	###########	###########	348,752	3.2%	###########	###########	1,409,519	1.1%
OTHER OPERATING REVENUE	358,856	1,272,113	(913,258)	(71.8%)	4,407,034	7,097,071	(2,690,037)	(37.9%)
TOTAL NET REVENUE	11,613,166	12,177,671	(564,505)	(4.6%)	133,904,610	135,185,127	(1,280,517)	(0.9%)
EXPENSE								
SALARIES AND WAGES	4,196,408	4,783,165	(586,757)	(12.3%)	52,808,573	54,907,878	(2,099,305)	(3.8%)
BENEFITS	960,219.06	##########	(912,210)	(48.7%)	12,079,139.60	14,702,320.27	(2,623,181)	(17.8%)
PAYROLL TAXES	358,789	347,131	11,658	3.4%	4,898,598	4,853,883	44,715	0.9%
PAID TIME OFF	451,349	18,892	432,457	2289.1%	4,000,329	262,890	3,737,438	1421.7%
CONTRACT LABOR								
REGISTRY	583	29,367	(28,784)	(98.0%)	116,669	181,586	(64,917)	(35.7%)
OTHER MEDICAL	0	38,190	(38,190)	(100.0%)	136,656	230,300	(93,644)	(40.7%)
OTHER CONTRACT LABOR	0	0	0	0.0%	0	0	0	0.0%
LABOR SUBTOTAL	5,967,348	7,089,173	(1,121,825)	(15.8%)	74,039,964	75,138,857	(1,098,893)	(1.5%)
SUPPLIES BILLABLE	1,507,323	840,700	666,623	79.3%	17,460,086	16,905,604	554,482	3.3%
SUPPLIES NON BILLABLE	360,099	302,998	57,101	18.8%	3,502,555	2,940,825	561,730	19.1%
PURCHASED SERVICES	2,374,054	1,868,712	505,341	27.0%	16,331,594	17,711,061	(1,379,467)	(7.8%)
PROFESSIONAL FEES	(19,112)	305,892	(325,004)	(106.2%)	1,221,975	1,444,017	(222,042)	(15.4%)
MANAGED CARE FEES	0	0	0	0.0%	0	0	0	0.0%
REPAIRS AND MAINTENANCE FEES	18,227	31,060	(12,834)	(41.3%)	408,657	363,261	45,396	12.5%
RENTS AND LEASES	235,596.6	192,287.9	43,309	22.5%	2,420,218.2	2,127,536.9	292,681	13.8%
INSURANCE	118,767.66	##########	(930,162)	(88.7%)	1,507,720.09	1,986,716.88	(478,997)	(24.1%)
UTILITIES	136,815	150,798	(13,983)	(9.3%)	1,951,374	2,210,618	(259,244)	(11.7%)
TAXES AND LICENSES	828,643	708,092	(79,449)	(11.2%)	7,476,459	7,105,287	371,173	5.2%
OTHER OPERATING EXPENSES	132,803	168,860	(36,057)	(21.4%)	1,589,886	1,455,567	134,319	9.2%
MANAGEMENT FEES	608,452	1,259,166	(650,714)	(51.7%)	7,082,750	6,991,817	90,933	1.3%
TOTAL OPERATING EXPENSES	12,069,016	13,966,669	(1,897,653)	(13.6%)	134,993,237	136,381,167	(1,387,930)	(1.0%)
EBITDA	(455,850)	(1,788,998)	1,333,148	74.5%	(1,088,628)	(1,196,040)	107,412	9.0%
DEPRECIATION	396,207	313,061	83,146	26.6%	4,295,563	3,248,763	1,046,800	32.2%
INTEREST INCOME	(190)	(908)	717	79.0%	(9,370)	(40,909)	31,539	77.1%
INTEREST EXPENSE	20,889	40,552	(19,662)	(48.5%)	374,237	317,655	56,582	17.8%
OTHER NON OPERATING	7,710	(10,627)	18,337	172.5%	105,017	(58,557)	163,574	279.3%
(GAIN)/ LOSS ON ASSET SALES	0	85,488	(85,488)	(100.0%)	(1,960)	95,615	(97,576)	(102.1%)
TOTAL NON OPERATING EXPENSES	424,615	427,566	(2,950)	(0.7%)	4,763,486	3,562,567	1,200,920	33.7%
PRETAX INCOME	(880,465)	(2,216,564)	1,336,099	60.3%	(5,852,114)	(4,758,607)	(1,093,508)	(23.0%)
INCOME TAX EXPENSE	0	0	0	0.0%	0	0	0	0.0%
NET INCOME / (LOSS) BEFORE EXTRA ITEMS	(880,465)	(2,216,564)	1,336,099	60.3%	(5,852,114)	(4,758,607)	(1,093,508)	(23.0%)
TOTAL EXTRAORDINARY ITEMS	0	0	0	0.0%	0	0	0	0.0%
NET INCOME (LOSS)	(880,465)	(2,216,564)	1,336,099	60.3%	(5,852,114)	(4,758,607)	(1,093,508)	(23.0%)

Prime Healthcare Services, LLC - Landmark
Consolidated Balance Sheet
12/31/2016

DESCRIPTION	12/31/2016 Consolidated	12/31/2016 LMC	12/31/2016 LPOS	12/31/2016 RHRI	12/31/2015 PRIOR YR COMB.	CHANGE-AMT	CHANGE-PCT
CASH AND EQUIVALENTS	10,156,181.04	10,101,106.92	29,405.81	25,668.31	1,367,241.95	8,788,939.09	643%
ACCOUNTS RECEIVABLE	192,627,759.65	179,734,886.43	2,889,561.29	10,023,311.93	100,004,714.73	92,823,044.92	248%
ALLOWANCES & BAD DEBT	(172,814,761.30)	(163,631,123.44)	(1,557,263.31)	(7,828,374.55)	(78,644,705.25)	(94,170,056.05)	120%
NET ACCOUNTS RECEIVABLES	19,812,998.35	16,103,762.99	1,312,297.98	2,396,937.38	21,360,009.48	(1,547,011.13)	-7%
OTHER RECEIVABLES	84,558.52	75,432.37	7,532.73	1,593.42	101,622.94	(17,064.42)	-17%
INVENTORY	2,017,308.06	1,974,562.54	5,565.00	37,180.52	2,497,233.15	(479,925.09)	-19%
PRE-PAID INSURANCE	22,233.16	12,165.54	-	10,067.62	27,794.21	(5,561.05)	-20%
OTHER CURRENT ASSETS	358,178.22	355,890.40	-	2,287.82	415,368.17	(57,189.95)	-14%
OTHER PRE-PAID EXPENSES	904,202.33	817,289.91	-	86,932.42	1,181,647.37	(277,445.04)	-23%
CURRENT ASSETS	33,355,659.68	29,440,210.67	1,354,801.52	2,560,647.49	26,950,917.27	6,404,742.41	24%
RP LT NOTES RECEIVABLE	2,813,269.62	-	-	2,813,269.82	-	2,813,269.62	0%
FIXED ASSETS	50,188,455.09	49,224,746.07	331,562.49	612,146.53	41,382,839.20	8,805,615.89	21%
ACCUMULATED DEPRECIATION	(9,574,454.50)	(9,268,296.74)	(78,254.21)	(207,903.55)	(5,273,710.49)	(4,300,744.01)	82%
NET FIXED ASSETS	40,594,000.59	39,936,449.33	253,308.28	404,242.98	36,089,128.71	4,504,871.88	12%
GOODWILL & INTANGIBLES	24,388.56	4,999.85	19,388.84	(0.13)	24,721.92	(333.36)	-1%
LONG TERM ASSETS	43,431,658.77	39,941,449.18	272,697.12	3,217,512.47	36,113,850.63	7,317,808.14	20%
ASSETS	76,787,318.45	69,381,659.85	1,627,498.64	5,778,159.98	63,064,767.90	13,722,550.55	22%
NOTES & LOANS PAYABLE	(139,846.83)	(139,846.83)	-	-	(82,823.29)	(57,023.54)	69%
SHORT TERM LEASES	(2,125,621.65)	(2,100,396.44)	(4,740.29)	(20,484.92)	(1,529,520.33)	(596,101.32)	39%
ACCOUNTS PAYABLE	(4,230,475.94)	(3,886,575.61)	(222,783.12)	(119,117.21)	(6,668,107.07)	2,437,631.13	-37%
ACCRUED PAYROLL	(1,048,648.59)	(838,318.81)	(117,414.73)	(92,915.05)	(845,276.52)	(203,372.07)	24%
ACCRUED TIME OFF	(3,758,543.71)	(3,391,225.79)	(135,533.61)	(231,784.31)	(4,024,884.13)	266,340.42	-7%
ACCR PAYR TAXES & DEDUCT	(1,451,978.03)	(1,289,749.63)	(48,600.72)	(113,627.68)	-	-	0%
OTHER ACCRUED	991,184.11	1,050,610.14	-	(59,426.03)	(163,845.56)	1,154,829.67	-705%
IBNR	(962,833.00)	(962,833.00)	-	-	(962,833.00)	-	0%
3RD PARTY SETTLEMENTS	(1,002,485.49)	(367,397.49)	-	(635,088.00)	-	-	0%
OTH CURRENT LIABILITIES	(833,070.59)	(816,807.34)	7,445.28	(23,708.53)	(625,092.57)	(7,978.02)	1%
CURRENT LIABILITIES	(14,362,319.72)	(12,544,540.80)	(521,627.19)	(1,296,151.73)	-	-	0%
INTERCOMPANY	(23,423,121.98)	(6,527,810.43)	(12,711,370.13)	(4,183,941.42)	(9,532,374.81)	(13,890,747.17)	2132%
INTRACOMPANY	(12,872,880.06)	(12,681,391.18)	-	(191,488.90)	(8,088,605.82)	(4,784,274.44)	59%
DEFERRED CREDITS	(333,754.00)	(333,754.00)	-	-	(333,754.00)	-	0%
RP LT NOTES PAYABLE	(14,049,274.20)	(14,049,274.20)	-	-	-	(14,049,274.20)	0%
LT CAPITAL LEASES	(4,838,727.12)	(4,795,097.73)	(7,198.14)	(36,431.25)	(5,721,543.37)	882,816.25	-15%
LT LOANS PAYABLE	(444,737.33)	(444,737.33)	-	-	(362,852.67)	(81,884.66)	23%
LONG TERM LIABILITIES	(55,962,494.69)	(36,832,064.85)	(12,718,568.27)	(4,411,881.57)	(24,039,130.47)	(31,923,364.22)	133%
LIABILITIES	(70,324,814.41)	(51,376,605.65)	(13,240,195.46)	(5,708,013.30)	-	-	0%
ADDL PAID-IN CAPITAL	(15,536,932.15)	(14,705,564.49)	(124,276.66)	(708,991.00)	(15,692,781.48)	153,849.33	-1%
RETAINED EARNINGS	9,134,234.53	(3,241,583.29)	11,736,973.48	838,844.34	3,282,120.34	5,852,114.19	178%
EQUITY	(6,404,697.62)	(17,947,247.78)	11,612,696.82	(70,148.66)	(12,410,661.14)	8,005,963.52	-48%
LIABILITIES & EQUITY	(76,729,512.03)	(69,323,853.43)	(1,627,498.64)	(5,778,159.98)	-	-	0%
	(0)	(0)	(0)	-	-	(0)	

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JACA architects

January 10, 2017

Landmark Medical Center
115 Cass Avenue
Woonsocket, RI 02895

RE: Certificate of Need Submission for a Certified Level III Trauma Center

Project Energy Considerations

The proposed project will include energy efficiency initiatives in several categories. The following is a list of energy efficiency opportunities for the various project components.

Site

The design for the project site will comply with all applicable codes for storm water runoff. Where possible landscape features will be included in reduce paved surface on site.

Site lighting calculations will be performed to reduce light spillover to adjacent properties and ensure that the most efficient type of fixtures are specified.

Building Envelope

The building envelope will be designed and specified to comply with the 2012 IECC as adapted by the state of Rhode Island. Exterior envelope insulation and weather proofing will be detailed as required. Exterior glazing will be specified with Low E coatings to reduce interior solar gain. The type and color of the roof will be chosen to reduce heat absorption.

Interior Materials

Interior details will be specified to assist in energy efficiency. Window shades will be included to reduce solar gain. The design of vestibules will include air breaks to reduce the need for supplemental heating. The overall interior lighting design

9 billings road
north quincy, ma 02171

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will include calculations to ensure lighting efficiency and LED fixtures will be specified.

Mechanical Systems

The Mechanical Systems for the project will be designed in compliance ASHRAE 90.1. The design of the systems and selection of equipment will include a review of energy efficiency opportunities.

Sincerely,

Anthony F. Cavallaro, AIA
President

RI Registration Number: 2258
RI Certificate of Authorization Number: ARC.0010248-COA

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north quincy, ma 02171

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see clipped

for

12/31/18 application

Revised: May 16, 2014

Prime Healthcare Services, Inc.

Period: October 18, 2013* – January 31, 2014

Government Agencies: California Department of Public Health ("CDPH")

Name of Entity	Reason for Action	Month	Penalty Paid	Paid/ Appealed
Huntington Beach Hospital	Late reporting of incident	November	$6,300 total	Paid
Alvarado Hospital Medical Center	Patient fall	November	$50,000	Appealed
Garden Grove Hospital Medical Center	Medicine Distribution and Administration	January	$50,000	Appealed

Note: As of October 18, 2013, Shasta Regional Medical Center had not paid the fine of $95,000 to CDPH relating to allegations concerning the disclosure of protected health information. That fine has now been paid.

Note: As noted in Supplementary Questions, dated September 17, 2013, to the Hospital Conversion Application, CDPH had fined Desert Valley Hospital $50,000 in August, 2013. Prime Healthcare's appeal continues.

*Date of the last filing of responses to Supplemental Questions to the Hospital Conversion Application.

Prepared: May 6, 2014

Prime Healthcare Services, Inc.

Period: April 1, 2014-May 1, 2014

Government Agencies: None.

Prime Healthcare Services, Inc. did not receive any deficiencies in final form from a governmental agency during this time period.

Prime Healthcare Services, Inc.

Period: July 1, 2014 – July 31, 2014

Government Agencies: None.

Prime Healthcare Services, Inc. did not receive any deficiencies in final form from a governmental agency during this time period.

Prime Healthcare Services, Inc.

Period: August 1, 2014 – August 30, 2014

Government Agencies: None.

Prime Healthcare Services, Inc. did not receive any deficiencies in final form from a governmental agency during this time period.

Prime Healthcare Services, Inc.

Period: September 1, 2014 – September 31, 2014

Government Agencies: None.

Prime Healthcare Services, Inc. did not receive any deficiencies in final form from a governmental agency during this time period.

Prime Healthcare Services, Inc.

Period: October 1 – October 31, 2014

Government Agencies: California Department of Public Health ("CDPH")

Name of Entity	Reason for Action	Month	Penalty Assessed	Paid/ Appealed
Garden Grove Hospital Medical Center	Civil penalty for delayed reporting of adverse event	October, 2014	$2,300.00	Appealed

Prime Healthcare Services, Inc.

Period: November 1 – November 30, 2014

Government Agencies: Nevada Department of Health and Human Services ("NDHHS")

Name of Entity	Reason for Action	Month	Penalty Assessed	Paid/ Appealed
Saint Mary's Medical Center	Administrative penalty for failing to register their mammography equipment with an accreditation company. Attached is the notice of penalty.	November, 2014	$10,000.00	Appealed

Prime Healthcare Services, Inc.

Period: December 1, 2014 – December 31, 2014

Government Agencies: None.

Prime Healthcare Services, Inc. did not receive any deficiencies in final form from a governmental agency during this time period.

Prime Healthcare Services, Inc.

Period: January 1, 2015 – January 31, 2015

Government Agencies: None.

Prime Healthcare Services, Inc. did not receive any deficiencies in final form from a governmental agency during this time period.

Prime Healthcare Services, Inc.

Period: February 1, 2015 – February 28, 2015

Government Agencies: None.

Prime Healthcare Services, Inc. did not receive any deficiencies in final form from a governmental agency during this time period.

Prime Healthcare Services, Inc.

Period: March 1, 2015 – March 30, 2015

Government Agencies: None.

Prime Healthcare Services, Inc. did not receive any deficiencies in final form from a governmental agency during this time period.

Prime Healthcare Services, Inc.

Period: June 1, 2015 - June 30, 2015

Government Agencies: None.

Prime Healthcare Services, Inc. did not receive any deficiencies in final form from a governmental agency during this time period.

Prime Healthcare Services, Inc.

Period: July 1, 2015 - December 31, 2015

Government Agencies: None.

Prime Healthcare Services, Inc. did not receive any deficiencies in final form from a governmental agency during this time period.

Prime Healthcare Services, Inc.

Period: January, 2016 –December, 2016

Government Agencies: Various

Name of Entity	Reason for Action	Month	Penalty Assessed/ Paid	Paid/ Appealed
Paradise Valley Hospital	Alleged deficiencies	February	$0.00	Corrected
Garden City Hospital	Deficiencies	May, 2016	$0.00	Corrected
St. Mary's General Hospital	Settlement	June, 2016	$0.00	Settlement
Shasta Regional Medical Center	Alleged HIPAA breaches	July, 2016	$42,500.00	Appealed
Shasta Regional Medical Center	Alleged HIPAA breaches	July, 2016	$75,000.00	Appealed

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Press

Prime Healthcare
Saving hospitals. Saving jobs. Saving lives.

May 25, 2016

Prime Healthcare Statement on Recent DOJ Action

(Ontario, CA – May 25, 2016) – Prime Healthcare has released the following statement by General Counsel Troy Schell, regarding the recent motion filed by the US Department of Justice:

"Prime Healthcare Services is aware that the US Department of Justice (DOJ) has filed a partial motion to intervene into the lawsuit filed in 2011 and believes it will be exonerated.

"The allegations under investigation arise from complex regulation and a lack of clarity between what federal regulators and physicians believe necessary to adequately document medical necessity for hospital admission.

"Similar investigations have involved almost every major health system and hundreds of hospitals across the country.

"We have great confidence in the decision-making and medical judgment of our physicians. The care physicians have deemed necessary is in the best interests of patients and their safety. Prime Healthcare is routinely recognized for quality and safety of care and has been awarded more patient safety awards than any other health system in the country by Healthgrades.

"The Federal government routinely audits hospitals. Thousands of Prime Healthcare cases have been reviewed and all have been deemed appropriate and necessary based upon the medical judgment of the physician. Other routine audits by independent agencies including The Joint Commission (TJC), the Healthcare Facilities Accreditation Program (HFAP) and the California Department of Public Health (CDPH) have also concluded that there have been no deficiencies or inaccuracies in clinical documentation. Based on this precedent, we expect a similar result in the current investigation and will continue to fully cooperate and provide any necessary information.

"In conclusion, we are hopeful that upon further review, it will be evident that medical documentation reflects the clinical decision making of physicians acting in the best interests of their patients, and consistent with Prime Healthcare's commitment to providing the highest quality of care to every patient."

Prime Healthcare | 3300 E. Guasti Road | Ontario, CA 91761 | Tel (909) 235-4400
www.primehealthcare.com

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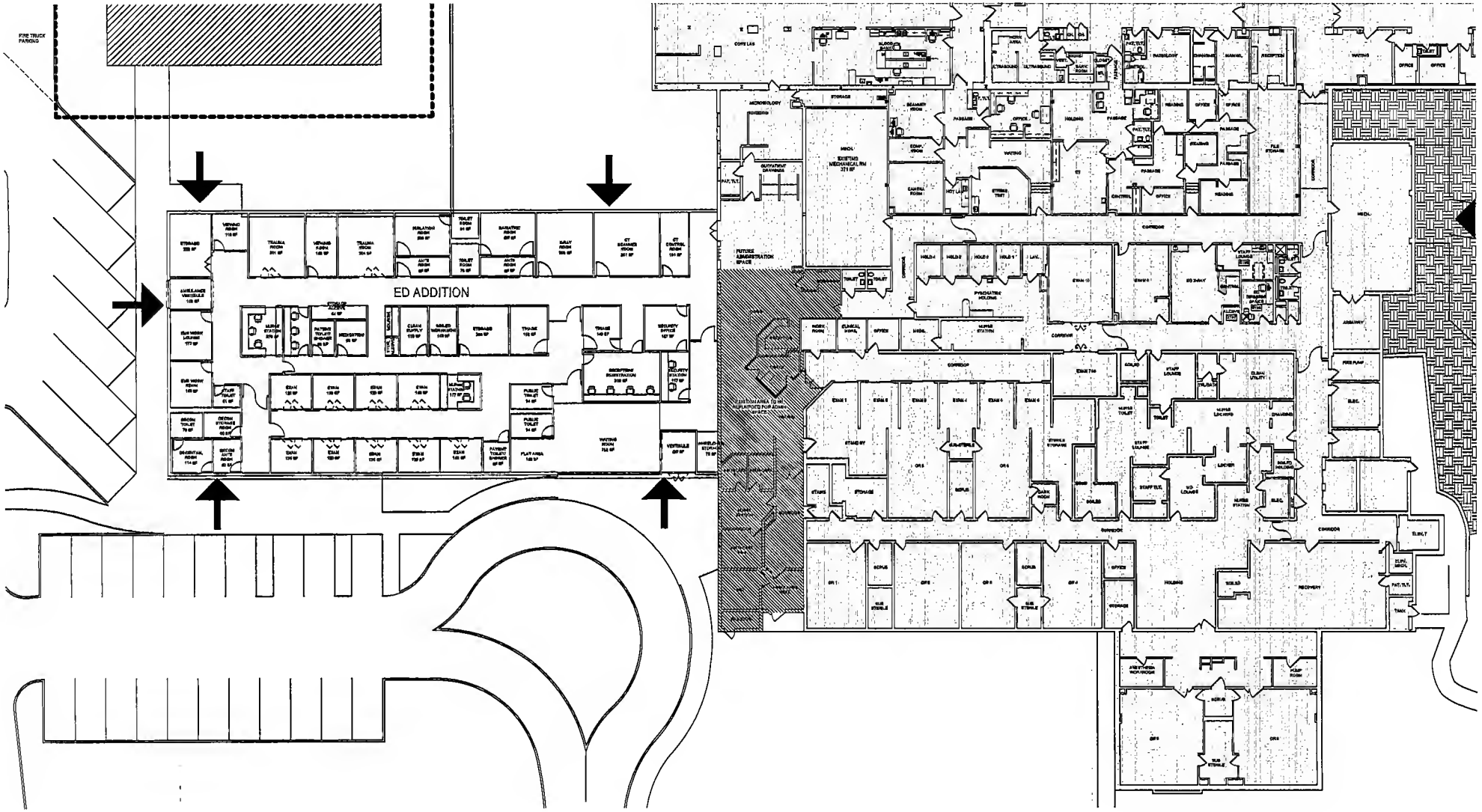
pls put colored
paper between
clipped pages.

Thx



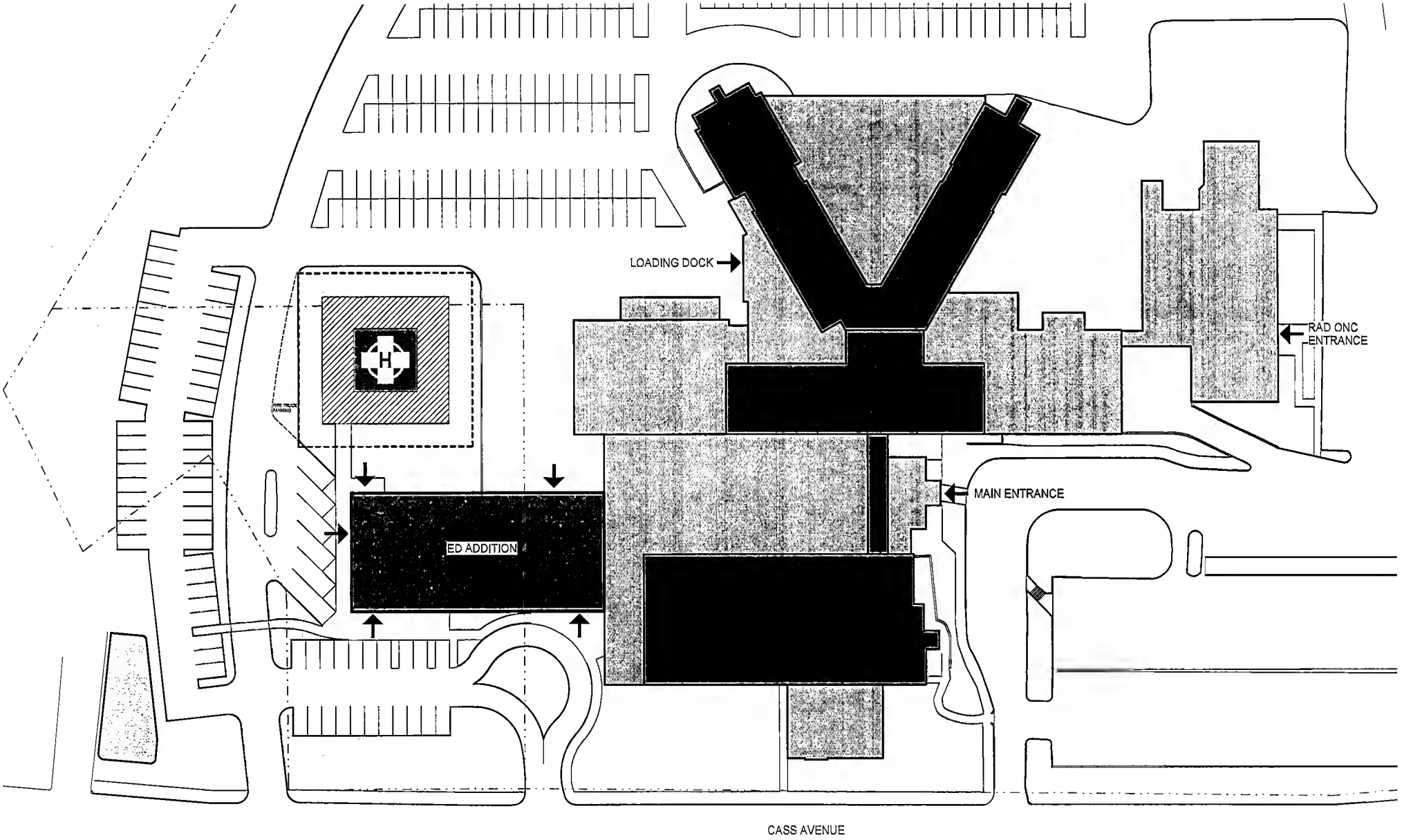
Landmark Medical Center

Landmark Medical Center
Emergency Department Project

PROPOSED LEVEL III TRAUMA CENTER

Date: 01/10 17
Scale: 3/32" = 1'-0"

JACA architects



Landmark Medical Center

Landmark Medical Center
Emergency Department Project

PROPOSED LEVEL III TRAUMA CENTER

Date: 01/10 17
Scale: 1/64" = 1'-0"

JACA architects

JACA architects

January 10, 2017

Landmark Medical Center
115 Cass Avenue
Woonsocket, RI 02895

RE: Certificate of Need Submission for a Certified Level III Trauma Center

Compliance with Applicable Code and Regulatory Requirements

The proposed project site and floor plans have been designed to comply with all current building code and regulatory requirements. The design utilized the current emergency services section of the FGI Guidelines for Design and Construction of Hospital and Healthcare Facilities. The design also complies with applicable sections of the following Codes:

2012 IBC

2012 IECC

2014 FGI Guidelines

NFPA 101

ASHRAE 90.1

2010 ADA Standards for Accessible Design

Sincerely,

Anthony F. Cavallaro, AIA
President

RI Registration Number: 2258
RI Certificate of Authorization Number: ARC.0010248-COA

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Book: 2076 Page: 90

TAX $ 56,392.00
DATE 12/31/13
RECORDER R.B.
CITY OF WOONSOCKET

SPECIAL MASTER'S DEED

013418

REAL ESTATE CONVEYANCE TAX

I, Jonathan N. Savage, in my capacity as and only as the duly appointed and qualified Permanent Special Masters of **LANDMARK MEDICAL CENTER, INC. ("LMC"), NORTHERN RHODE ISLAND REHAB MANAGEMENT ASSOCIATES, L.P. ("RHRI") and LANDMARK HEALTH SYSTEMS, INC. ("LHS")** (LMC, RHRI and LHS shall be collectively referred to herein as "Grantor") and not individually, by the power conferred by the Orders of the Providence County Superior Court of the State of Rhode Island appointing Permanent Special Master entered on the 26th day of June, 2008, the 9th day of December, 2008, and the 23rd day of October, 2008, respectively; and by the power conferred by the Order of the Providence County Superior Court of the State of Rhode Island granting the Special Masters' Petition to Sell Assets to Prime Healthcare Services-Landmark, LLC Free and Clear of Liens, Claims and Encumbrances entered on the 26th day of November, 2013, in the Mastership proceedings pending before that Court, captioned as Gary J. Gaube, Chief Executive Officer and Trustee vs. Landmark Medical Center (docketed as P.B. No.: 08-4371), Gary J. Gaube, Chief Executive Officer and Trustee vs. Landmark Health Systems, Inc. (docketed as C.A. No.: 08-5893) and Richard R. Charest, Chief Executive Officer vs. Northern Rhode Island Rehab Management Associates, L.P. (docketed as PB No.: 08-7186) (collectively the "Mastership Proceedings"), and by every other power thereunto me enabling, in consideration of **FOURTEEN MILLION NINETY-NINE THOUSAND FOUR HUNDRED THIRTY and 48/100 ($14,099,430.48) DOLLARS**, the receipt of which is hereby acknowledged, do hereby grant, bargain, sell and convey unto **Prime Healthcare Services-Landmark, LLC**, a Delaware limited liability company, its successors and assigns, free and clear of all interests, claims, liens and encumbrances, together with the benefit of all of Grantor's right, title and interest in any and all easements, if any, appurtenant to the property but expressly subject to any and all currently existing easements, use restrictions, municipal ordinances and/or federal and state laws and regulations, all of my right, title and interest as said Permanent Special Masters in and to certain parcels of real estate and improvements thereon located in Woonsocket, Rhode Island and North Smithfield, Rhode Island, being specifically designated as Woonsocket Tax Assessor's Plat 37A, Lot 190 ("Parcel 1"); Woonsocket Tax Assessor's Plat 37A, Lot 1 ("Parcel 2") and Woonsocket Tax Assessor's Plat 40A, Lot 1 ("Parcel 3") and as more particularly described in Exhibit A

annexed hereto and hereby incorporated by reference herein (Parcel 1, Parcel 2 and Parcel 3 are collectively referred to herein as the "Property").

EXCEPT AS EXPRESSLY SET FORTH HEREIN, THIS CONVEYANCE IS MADE "AS IS" AND "WHERE IS" AND WITHOUT ANY REPRESENTATIONS OR WARRANTIES OF ANY KIND WHATSOEVER, INCLUDING BUT NOT LIMITED TO, ANY REPRESENTATIONS OR WARRANTIES CONCERNING QUANTITY, QUALITY, DURABILITY, CONDITION, MERCHANTABILITY, FITNESS FOR ANY PURPOSE, OR ANY OTHER ASPECT OF THE PROPERTY.

This conveyance is made by the Special Masters appointed by the Providence County Superior Court of the State of Rhode Island, and no withholding tax is required under R.I.G.L. §44-30-71.3.

Notwithstanding anything herein to the contrary, the Special Masters' execution of this instrument is in his capacity as Special Master only and shall not render him personally liable in any manner whatsoever.

WITNESS my hand this 24th day of December, 2013.

Jonathan N. Savage, Esq. in his capacity as and only as the Special Masters of Landmark Medical Center, Landmark Health Systems, Inc. and Northern Rhode Island Rehab Management Associates, L.P., and not individually

STATE OF RHODE ISLAND
COUNTY OF PROVIDENCE

In Pawtucket, in said County on the _____ day of December, 2013, personally appeared Jonathan N. Savage, Permanent Special Master of Landmark Medical Center, Landmark Health Systems, Inc. and Northern Rhode Island Rehab Management Associates, L.P. to me known and known by me to be the party executing the foregoing instrument, and he acknowledged said instrument by him executed to be his free act and deed as and only as Permanent Special Master of Landmark Medical Center, Landmark Health Systems, Inc. and Northern Rhode Island Rehab Management Associates, L.P. and not individually.

Notary Public
My commission expires: 4/1/14

Exhibit A

The Property

Real property in the City of Woonsocket, County of Providence, State of Rhode Island, described as follows:

PARCEL 1

A certain lot or parcel of land with all the buildings and improvements thereon situated on the southerly side of Cass Avenue, the northeasterly side of Cumberland Street, and the northeasterly side of Cumberland Hill Road, in the City of Woonsocket, County of Providence, State of Rhode Island, and shown on that unrecorded plan entitled "Plan of Land For Landmark Medical Center, Woonsocket Unit, Woonsocket. R.I. July 1989. Scale: 1 inch equals 40 feet" by Robert C. Cournoyer & Assoc., Inc., more particularly bounded and described as follows:

Beginning at a point on the northeasterly line of said Cumberland Hill Road, said point being the most southwesterly corner of land now or formerly of the City of Woonsocket, and being the most southeasterly corner of the parcel hereby described:

thence: Northwesterly, along the northeasterly line of said Cumberland Hill Road, along a curved line to the right having a radius of seven hundred twenty-nine and fifty-five one-hundredths (729.55) feet, twenty-five and four one-hundredths (25.04) feet to land now or formerly of Woonsocket Medical Center;

thence: N 34°-55'-16" E, along said Woonsocket Medical Center land, two hundred seventy-three and fifty-four one-hundredths (273.54) feet;

thence: Northwesterly, along a curved line to the left having a radius of seventy and zero one hundredths (70.00) feet, one hundred nine and ninety-six one-hundredths (109.96) feet;

thence: N 55°-04'-44" W, one hundred twenty and zero one-hundredths (120.00) feet;

thence: Northwesterly, along a curved line to the left having a radius of three hundred five and zero one-hundredths (305.00) feet, ninety-three and sixteen one-hundredths (93.16) feet;

thence: Northwesterly, along a curved line to the right having a radius of one hundred thirty-five and zero one-hundredths (135.00) feet, one hundred twenty-one and twelve one-hundredths (121.12) feet;

thence: S 84°-43'-22" W, twenty-one and seventy-four one-hundredths (21.74) feet to the northeasterly line of said Cumberland Street, the last six lines bounding on said Woonsocket Medical Center land;

thence: Northwesterly, along the northeasterly line of said Cumberland Street, along a curved line to the left having a radius of seven hundred ninety and eighty one-hundredths (790.80) feet, one hundred forty-five and fifty-nine one-hundredths (145.59) feet;

thence: N 63°-20'-15" W, one hundred eighty-one and forty-five one-hundredths (181.45) feet;

thence: N 43°-12'-49" W, forty-four and thirty-three one-hundredths (44.33) feet to other land of said Landmark Medical Center, the last three lines bounding on the northeasterly line of said Cumberland Street;

thence: N 11°-40'-09" E, along said Landmark Medical Center other land, sixty-nine and seventy-one one-hundredths (69.71) feet;

thence: N 15°-08'-07" W, seventeen and seventy-nine one-hundredths (17.79) feet;

thence: N 18°-48'-35" E, thirty-nine and sixty-seven one-hundredths (39.67) feet;

thence: N 28°-26'-07" W, forty-six and sixty-seven one-hundredths (46.67) feet;

thence: N 40°-37'-22" W, twenty-four and ninety-seven one-hundredths (24.97) feet;

thence: N 26°-36'-42" W, twenty-nine and nine one-hundredths (29.09) feet;

thence: N 28°-15'-41" W, one hundred fifty-five and ninety-six one-hundredths (155.96) feet to the southerly line of said Cass Avenue, the last seven lines bounding on said Landmark Medical Center other land;

thence: N 84°-02'-55" E, along the southerly line of said Cass Avenue, one hundred ten and four one-hundredths (110.04) feet;

thence: N 79°-45'-34" E, two hundred and fifty-six one-hundredths (200.56) feet;

thence: N 84°-02'-55" E, five hundred fourteen and ninety-eight one-hundredths (514.98) feet to other land of said Landmark Medical Center, the last three lines bounding on the southerly line of said Cass Avenue;

thence: S 05°-57'-05" E, along said Landmark Medical Center other land, three hundred and zero one-hundredths (300.00) feet;

thence: N 84°-02'-55" E, two hundred ninety-seven and forty-two one-hundredths (297.42) feet to land now or formerly of Richard D. & Elizabeth M. Lataille, the last two lines bounding on said Landmark Medical Center other land;

thence: S 25°-33'-44" W, along said Lataille land and land now or formerly of Sylvio & Florence Potvin, two hundred ninety-eight and ninety-eight one-hundredths (298.98) feet to land now or formerly of the City of Woonsocket;

thence: S 70°-33'-44" W, along said City of Woonsocket land forty-four and zero one-hundredths (44.00) feet;

thence: S 29°-31'-18" W, two hundred seventy-three and fifty-three one-hundredths (273.53) feet;

thence: S 41°-10'-40" W, one hundred fifty-one and seventy-four one-hundredths (151.74) feet;

thence: S 34°-55'-16" W, three hundred eighty-five and eighty one-hundredths (385.08) feet to the northeasterly line of said Cumberland Hill Road and the point of beginning, the last four lines bounding on said City of Woonsocket land.

Together with appurtenant water rights contained in that certain instrument recorded in Book 23, Page 515.

PARCEL 2

A certain lot or parcel of land situated on the southerly side of Cass Avenue, in the City of Woonsocket, County of Providence, State of Rhode Island, bounded and described as follows:

Beginning at a point in the southerly line of Cass Avenue a corner of land of Woonsocket Hospital Corp. and the northerly corner of the lot hereby described, thence easterly with said southerly line of Cass Avenue, 75 feet to land now or formerly of George and Alma Gaouette; thence southerly at right angles to said southerly line of Cass Avenue and bounding on said Gaouette land about 29 feet to a point directly in range northwesterly at the southwesterly line of a boundary of a tract of land conveyed by deed from Charles Miles et ux to Philanda A. Rawlatton dated March 6, 1886, and recorded in Book 33, Page 54; thence southeasterly following said range and continuing with said Gaouette land about 142 feet more or less to a stone bound at a corner of said Woonsocket Hospital Corp., thence southwesterly with said Hospital land about 50 feet to a stone bound; thence northwesterly continuing with said Hospital land about 100 feet; thence northerly still continuing with said Hospital land to the point and place of beginning.

PARCEL 3

A certain lot or parcel of land with all the buildings and other improvements thereon, situated on the southerly side of Cass Avenue, in the City of Woonsocket, County of Providence, State of Rhode Island, bounded and described as follows:

Beginning at a point on the southerly side of said Cass Avenue which point is the northwesterly corner of land now or formerly of Fernande Devisch and being the northeasterly

corner of the lot hereby described; thence S. 02° 05' W., one hundred twenty (120.00) feet to a concrete bound; thence S. 27° 28' E., ninety-nine and three-tenths (99.30) feet to a concrete bound, the last two (2) lines bounding on said Devisch land; thence N. 54° 52' E., still continuing with said Devisch land and land now or formerly of George and Alma Gaouette one hundred and three-tenths (100.30) feet to a concrete bound; thence S. 23° 57' E., still continuing with said Gaouette land and land now or formerly of Lea Loiselle one hundred fourteen and three-tenths (114.30) feet to land now or formerly of Alphonse and Doris B. Pepin; thence S. 33° 23' 30" W. with said Pepin land sixty and two one-hundredths (60.02) feet; thence N. 88° 00' W. two hundred ninety-seven and forty-two one-hundredths (297.42) feet; thence N. 02° 00' E., three hundred (300.00) feet to the aforesaid Cass Avenue, the last two (2) lines bounding on land now or formerly of The Woonsocket Hospital; thence S. 88° 00' E., with said Cass Avenue one hundred fifty (150.00) feet to the point of beginning.

GRANTEES ADDRESS:

3300 EAST GUASTI ROAD 3RD FLOOR
ONTARIO, CA 91761

RECEIVED IN WOONSOCKET R.I.
DATE Dec 31,2013 TIME 10:05:42A
Christina Harmon-Duarte, CITY CLERK

CITY OF WOONSOCKET, RHODE ISLAND
DEPARTMENT OF PLANNING & DEVELOPMENT

January 27, 2017

Anthony F. Cavallaro
c/o JACA Architects
9 Billings Rd
North Quincy, MA. 02171

Dear Anthony,

Thank you for your Design Review Application for a proposed expansion of the emergency room at Landmark Medical Center, 115 Cass Avenue, Woonsocket, R.I. AP 37 Lots 1 and 190. Please accept this letter as a formal acknowledgement of receipt of said application.

This application will also have to be reviewed by the Woonsocket Planning Board for approval of a major sub-division since this project involves two separate lots in a C-1 Zoning District.

If I can be any further assistance please feel free to contact me.

Sincerely,

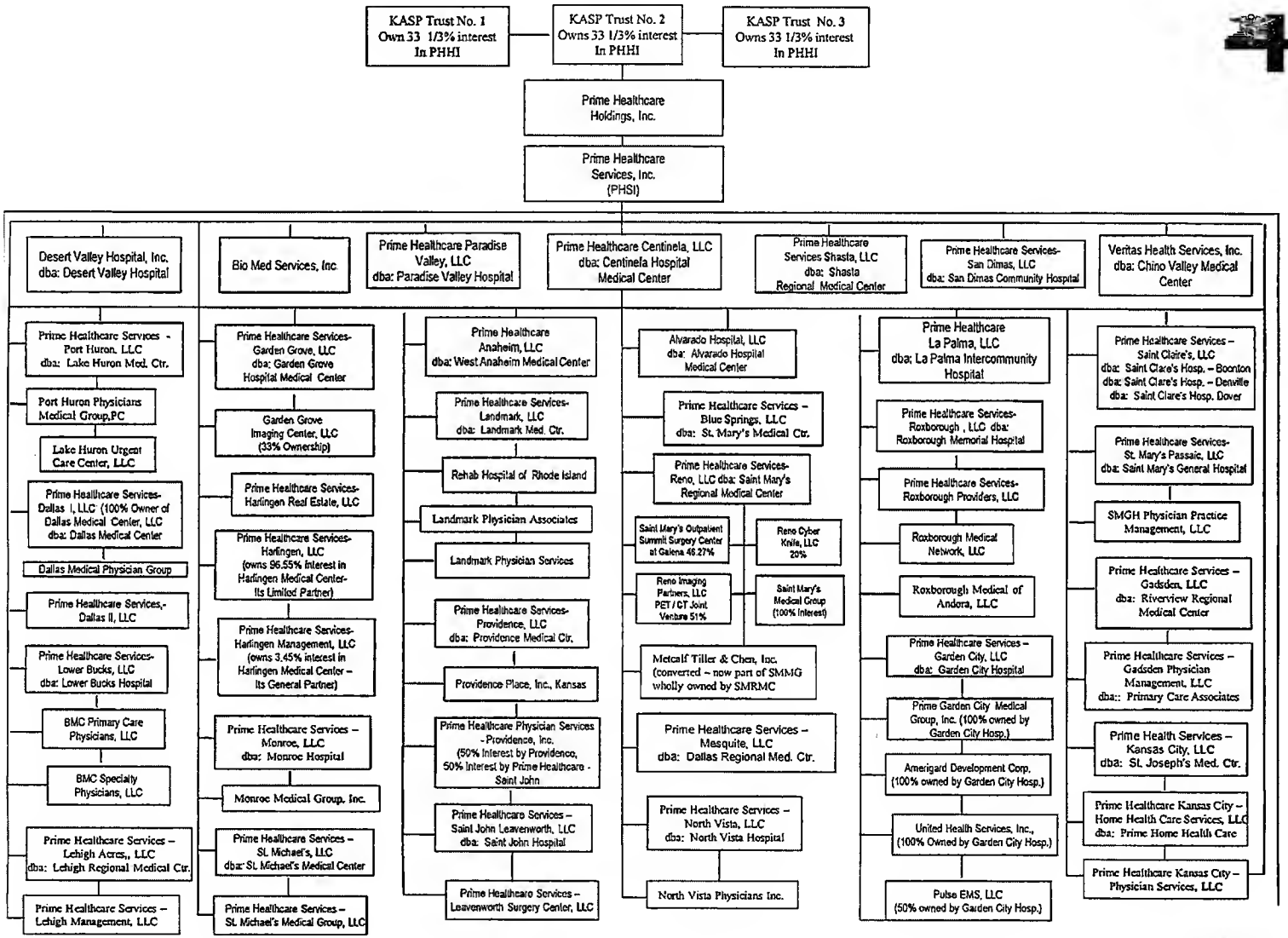
Carl J. Johnson
Zoning Official and A.D.A. Compliance Officer
City of Woonsocket R.I.
401-762-6400 ext. 2966

CC: N. David Bouley Director of Planning and Development
Rui Almeida Deputy Director of Planning and Development/ City Planner
Brad Ward Building Official

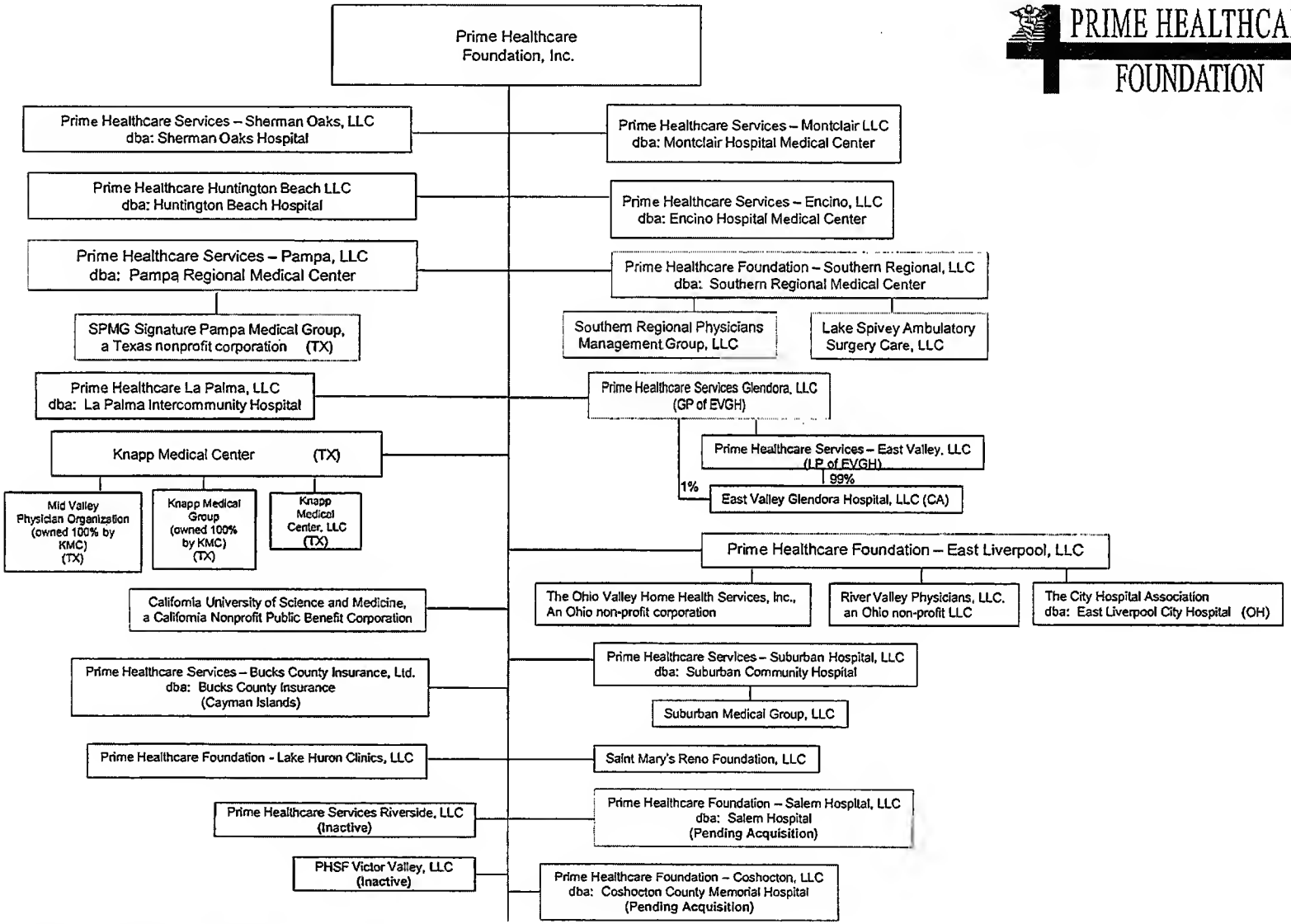
G

Pressed
colored paper
between each
clipped piece

PRIME HEALTHCARE SERVICES, INC.



Effective: 12/20/2016



PRIME HEALTHCARE FOUNDATION

15 TOP HEALTH SYSTEMS

THOMSON REUTERS

Effective 12-20-16

All entities are DE entities unless otherwise noted.

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "PRIME HEALTHCARE SERVICES - LANDMARK, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWELFTH DAY OF OCTOBER, A.D. 2012.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "PRIME HEALTHCARE SERVICES - LANDMARK, LLC" WAS FORMED ON THE NINETEENTH DAY OF SEPTEMBER, A.D. 2012.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE NOT BEEN ASSESSED TO DATE.

Jeffrey W. Bullock, Secretary of State

5215352 8300

121124738

AUTHENTICATION: 9912721

DATE: 10-12-12

You may verify this certificate online at corp.delaware.gov/authver.shtml

State of Delaware
Secretary of State
Division of Corporations
Delivered 06:11 PM 09/19/2012
FILED 06:07 PM 09/19/2012
SRV 121047256 - 5215352 FILE

STATE OF DELAWARE
LIMITED LIABILITY COMPANY
CERTIFICATE OF FORMATION

First: The name of the limited liability company is Prime Healthcare Services – Landmark, LLC.

Second: The address of its registered office in the State of Delaware is 615 S. Dupont Highway in the City of Dover, County of Kent, 19901. The name of its Registered Agent at such address is National Corporate Research, Ltd.

Third: The limited liability company is and shall remain an entity which (i) exists solely for the purpose of owning and/or leasing all or any portion of Landmark Medical Center and/or Rehabilitation Hospital of Rhode Island located in or about Woonsocket, Rhode Island, including real property and improvements related thereto, (the "Hospital") and the pursuit and conduct of any business venture or activity related thereto (the "Business"), (ii) conducts business only in its own name or the name of Landmark Medical Center and/or Rehabilitation Hospital of Rhode Island, (iii) does not engage in any business other than the ownership and/or leasing of all or any portion of the Hospital and the operation of the Business, (iv) does not hold, directly or indirectly, any ownership interest (legal or equitable) in any entity or any real or personal property other than the interest which it owns in the Hospital and the other assets incident to the operation of the Business, (v) does not have any debt and does not guarantee or otherwise obligate itself with respect to the debt of any other person or entity other than (A) as contemplated by financing arrangements with Medical Properties Trust, Inc. and its affiliates ("MPT") or arising in the ordinary course of business, (B) obligations in respect of any receivables or working capital loan or financing, including, without limitation, the revolving loan and security agreement dated on or about July 3, 2012, among Prime Healthcare Services, Inc. and certain of its subsidiaries, as borrowers, Healthcare Finance Group, LLC, as administrative agent and the lenders party thereto, as such agreement may be amended, amended and restated, supplemented or otherwise modified from time to time or (C) other obligations consented to by MPT; (vi) has its own separate books, records, accounts, financial statements and tax returns (with no commingling of funds or assets), (vii) holds itself out as being a company separate and apart from any other entity, and (viii) maintains all corporate formalities independent of any other entity.

In Witness Whereof, the undersigned has executed this Certificate of Formation this 19th day of September 2012.

By: _____
Michael J. Sarrao,
Authorized Person

RI SOS Filing Number: 201299454590 Date: 10/16/2012 12:07 PM

Filing Fee: $150.00

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
Office of the Secretary of State
Division of Business Services
148 W. River Street
Providence, Rhode Island 02904-2615

LIMITED LIABILITY COMPANY

APPLICATION FOR REGISTRATION

Pursuant to the provisions of Section 7-16-49 of the General Laws of Rhode Island, 1956, as amended, the undersigned foreign limited liability company hereby applies for a Certificate of Registration to transact business in the state of Rhode Island, and for that purpose submits the following statement:

1. The name of the limited liability company is:

   Prime Healthcare Services - Landmark, LLC

   ☐ This company has been duly organized in its state of formation as a low-profit limited liability company. (Check box if applicable)

2. The name, if different, under which it proposes to register and transact business in Rhode Island is:

3. The limited liability company is organized under the laws of **Delaware**

4. The date of its organization is **September 19, 2012**

5. The period of duration of the limited liability company is (if perpetual, so state) **Perpetual**

6. The address of the limited liability company's resident agent in Rhode Island is:

   222 Jefferson Blvd. (Street Address, not P.O. Box) Warwick (City/Town), RI 02888 (Zip Code)

   and the name of the resident agent at such address is ParaSearch, Inc. (Name of Agent)

7. The secretary of state is appointed the agent of the foreign limited liability company for service of process if at any time there is no resident agent or if the resident agent cannot be found or served following the exercise of reasonable diligence.

8. The address of any office required to be maintained in the state or other jurisdiction under the laws which the limited liability company is organized is:

   3300 East Guasti Road, 3rd Floor

   Ontario, CA 91761

9. The mailing address for the limited liability company is:

   3300 East Guasti Road, 3rd Floor

   Ontario, CA 91761

2012 OCT 16 P 12:07

Form No. 450
Revised: 07/12

FILED 1207
OCT 16 2012
BY

10. Management of the Limited Liability Company:

A. The limited liability company is to be managed ☑ by its members. ***(If you have checked this box, go to item no. 11.)***

or

B. The limited liability company is to be managed ☐ by one (1) or more managers. ***(If the limited liability company has managers at the time of the filing of these Articles of Organization, state the name and address of each manager.)***

Manager	Address

11. This application is accompanied by a certificate of good standing duly authenticated by the secretary of state or other authorized officer of the jurisdiction under which the foreign limited liability company was organized.

12. The date this Application for Registration is to become effective, if later than the date of filing, is:

(not prior to, nor more than 30 days after, the filing of this Application for Registration)

Under penalty of perjury, I declare and affirm that I have examined this Application for Registration, including any accompanying attachments, and that all statements contained herein are true and correct.

Date: October 12, 2012

Prime Healthcare Services - Landmark, LLC
Print Exact Name of Limited Liability Company Making Application

By _____
Signature of Authorized Person

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "PRIME HEALTHCARE SERVICES - LANDMARK, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWELFTH DAY OF OCTOBER, A.D. 2012.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "PRIME HEALTHCARE SERVICES - LANDMARK, LLC" WAS FORMED ON THE NINETEENTH DAY OF SEPTEMBER, A.D. 2012.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE NOT BEEN ASSESSED TO DATE.

Jeffrey W. Bullock, Secretary of State

5215352 8300

121124738

AUTHENTICATION: 9912721

DATE: 10-12-12

You may verify this certificate online at corp.delaware.gov/authver.shtml

State of Rhode Island and Providence Plantations

A. Ralph Mollis

Secretary of State

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

I, A. RALPH MOLLIS, Secretary of State of the State of Rhode Island and Providence Plantations, hereby certify that this document, duly executed in accordance with the provisions of Title 7 of the General Laws of Rhode Island, as amended, has been filed in this office on this day:

October 16, 2012 12:07 PM

A. RALPH MOLLIS

Secretary of State

83871-2-782041

OPERATING AGREEMENT

FOR

PRIME HEALTHCARE SERVICES – LANDMARK, LLC

THIS OPERATING AGREEMENT FOR PRIME HEALTHCARE SERVICES - LANDMARK, LLC (this "Agreement") is made and entered into by Prime Healthcare Services, Inc., a Delaware corporation (the "Member") effective as of the 20th day of September 2012.

ARTICLE 1
ORGANIZATION

Section 1.1 **Formation**. Pursuant to the Certificate of Formation (the "Articles of Formation") filed with the Delaware Secretary of State on or about September 19, 2012 (the "Commencement Date") an authorized representative of the Member formed a limited liability company under the corporate laws of the State of Delaware (the "Act"). The rights and liabilities of the Member will be as provided in the Act except as otherwise provided in this Agreement.

Section 1.2 **Name**. The business of the Company shall be conducted under the name of Prime Healthcare Services - Landmark, LLC. The Member may change the Company's name at any time and from time to time. The Member may also cause the Company to do business at the same time under more than one fictitious name if the Member determines that doing so is in the interest of the Company.

Section 1.3 **Character of Business**. Subject to any limitations set forth in the Articles of Formation, the Company may carry on any lawful activity permissible for a limited liability company under Delaware law.

Section 1.4 **Place of Business**. The principal office of the Company shall be located at 3300 East Guasti Road, 3rd Floor, Ontario, California, or at such other location as the Member may from time to time determine.

Section 1.5 **Location of Records**. The Company will maintain, at its principal office, all records pertaining to the Company as required by the Act.

Section 1.6 **Term**. The period of duration of the Company shall commence on the Commencement Date and shall be perpetual.

Section 1.7 **Statutory Agent**. The following company is hereby designated as the agent for service of process of the Company in the State of Delaware, until subsequently changed by the Member or the Manager: National Corporate Research, Ltd.

ARTICLE 2
MEMBERSHIP INTERESTS

Section 2.1 **Members.** The initial membership interest of the Member shall be 100%.

Section 2.2 **Certification.** The Company may issue certificates to evidence the membership interests of the Member and any additional Members admitted in accordance with this Agreement. Certificates representing the membership interests shall be in the form substantially as set forth in Exhibit A and valid upon due execution by any Manager or officer of the Company.

Section 2.3 **Opt-in to Article 8 of the Uniform Commercial Code.** The membership interests shall be securities governed by Article 8 of the Uniform Commercial Code, as applicable in all relevant jurisdictions.

ARTICLE 3
CAPITAL ACCOUNTS

Section 3.1 **Capital Contribution.** A Capital Account shall be maintained for the Member as shown on the books of the Company. The Member will not be required to make any capital contributions other than the initial capital contribution. The initial capital contribution of the Member is $10,000.00.

ARTICLE 4
MANAGEMENT OF COMPANY

Section 4.1 **Management.** The business and affairs of the Company shall be managed from time to time by the Member.

Section 4.2 **Officers.** Subject to the provisions of Section 4.3, the Member may appoint individuals to act as officers of the Company, which may include (a) a chairman; (b) a chief executive officer; (c) a president; (d) one or more vice presidents; (e) a secretary and/or one or more assistant secretaries; and (f) a treasurer and one or more assistant treasurers. The Member may delegate a portion of its management responsibilities to any such officers, as determined by the Member, from time to time, and such officers will have the authority to contract for, negotiate on behalf of and otherwise represent the interests of the Company as so authorized by the Member, provided that in no event will any officer have any rights, duties, powers or authority greater than that so delegated or that of the authorizing Member.

Section 4.3 **Major Decisions.** Notwithstanding any other provision of this Agreement, only the Member shall have the right or authority to take any of the following actions (each a "Major Decision") on behalf of the Company:

(a) Investing or otherwise acquiring any interest in any other business or entity;

(b) Issuing Membership Interests;

(c) Redeeming an Interest in the Company;

(d) Effecting any material change in the direction of the business of the Company;

(e) Selling, hypothecating or otherwise transferring or disposing of a material portion of the Company's assets other than in the ordinary course of business; or

(f) Merging, reorganizing or otherwise engaging in any business combination with any other entity, on behalf of the Company or otherwise.

ARTICLE 5
INCOME/LOSSES AND DISTRIBUTIONS TO MEMBER

Section 5.1 **Allocation of Income and Losses**. The net profits and losses of the Company shall be allocated to the Member and if more than one Member among the Members in accordance with their percentage interests of the Company and strictly in accordance with the requirements of Code Section 704(b) and the applicable regulations promulgated thereunder.

Section 5.2 **Distributions of Net Cash Flow and Net Cash Proceeds**. Distributions shall be made to the Member at such time as the Member determines.

ARTICLE 6
WITHDRAWAL OF A MEMBER

Section 6.1 **Withdrawal of a Member**. A person ceases to be a Member of this Company upon the occurrence of:

(a) Except as provided below, any of the events of Withdrawal as set forth in the Act;

(b) The Member assigns or transfers all of such Member's membership interest in accordance with this Agreement, regardless of whether the assignee or transferee of such membership interest is admitted as a Member of the Company in substitution of the assigning or transferring Member; or

(c) In the case of a Member that is a corporation, the filing of a Certificate of Dissolution, or its equivalent, for the corporation or the revocation of its charter, provided that its charter is not reinstated within ninety (90) days after revocation.

ARTICLE 7
TRANSFERS OF MEMBERSHIP INTERESTS

Section 7.1 **Voluntary Transfers of Membership Interests**. The membership interest of the Member may be voluntarily transferred at any time.

ARTICLE 8
DISSOLUTION OF COMPANY

Section 8.1 **Dissolution**. The Company shall be dissolved upon the occurrence of any of the following events:

(a) The occurrence of one or more of the events specified in this Agreement as causing the dissolution of the Company;

(b) The written statement of the Member to dissolve the Company; and

(c) Entry of a decree of judicial dissolution under the Act.

Upon the dissolution of the Company, the Member (or the successor of the Member with respect to the Member's membership interest) shall proceed, within one hundred eighty (180) days after notice of the event causing dissolution, with the winding up of the Company, and its assets shall be applied and distributed as provided in the Act; provided, however, that nothing in this Agreement shall be deemed to require the Company or any Member to pay any non-recourse debts or obligations of the Company.

Section 8.2. **Final Accounting**. The Member shall be furnished with a statement prepared by the Company's accountants, which shall set forth the assets and liabilities of the Company as of the date of the complete liquidation. Upon the compliance by the Member with the foregoing distribution plan, the Member shall cease to be a Member and the Member shall execute and cause to be filed a Certificate of Dissolution of the Company in compliance with the Act and any and all other documents necessary with respect to termination and cancellation.

ARTICLE 9
INVESTMENT REPRESENTATION

Section 9.1 **Investment Purposes**. The Member hereby represents and covenants that such Member is acquiring such Member's interest solely for investment purposes and not with a view to the distribution or resale thereof. Notwithstanding statements contained in other Articles of this Agreement, no membership interest may be offered or sold and no transfer of membership interest will be made either by the Company or the Member unless: (i) the sale or transfer of such membership interest is registered under the Securities Act of 1933, as amended from time to time, and is registered under the applicable provisions of state law; or (ii) an opinion of counsel, satisfactory to the Member as to form, substance and counsel, is delivered to the Company by the Member desiring to offer, sell, or transfer a membership interest, to the effect that no such registration is necessary.

ARTICLE 10
INDEMNIFICATION

Section 10.1 **Indemnification of Member, Manager and Officers**. The indemnification provisions of the Act (or any corresponding provision of a succeeding law) shall apply to the Company. The Company shall indemnify the Member, the Manager and the officers of the Company (each an "Indemnified Party"), and hold each of them harmless from and against any and all obligations, losses, damages, penalties, actions, judgments, suits, proceedings, costs, expenses and disbursements of any kind or nature whatsoever that may be imposed on, incurred by or asserted against the Indemnified Party (including, without limitation, all costs and expenses of defense, appeal and settlement) to the fullest extent permitted by the Act. The obligations of the Company under this Section 10.1 shall be satisfied solely from the assets of the Company, and the Member shall not have any personal liability on account thereof.

Section 10.2 **Insurance**. The Company shall have power to purchase and maintain insurance on behalf of any Indemnified party against any liability asserted against and incurred by such Indemnified Party in such Indemnified Party's capacity, or arising out of the Indemnified Party's status as such, whether or not the Company would have the power to indemnify the Indemnified Party against such liability under the provisions of this Article 10.

IN WITNESS WHEREOF, the Member has hereunto set its hand as of the date set forth above.

Prime Healthcare Services, Inc.

By: _____
Michael J. Sarrao
Senior Vice-President & Secretary

EXHIBIT A

FORM OF MEMBERSHIP INTEREST CERTIFICATE

Attached.

SEE REVERSE SIDE FOR RESTRICTIVE LEGEND(S)

Number – *[1]*

PRIME HEALTHCARE SERVICES - LANDMARK, LLC
A Delaware Limited Liability Company

THIS CERTIFIES THAT *_____* is the record holder of *_____ (___%)* of the membership interests of **Prime Healthcare Services - Landmark, LLC** (the "Company") transferable only on the books of the Company by the holder, in person or by such holder's duly authorized attorney, upon surrender of this certificate properly endorsed or assigned.

This certificate and the membership interest represented hereby are issued and shall be held subject to all the provisions of the Operating Agreement of the Company and any amendments thereto, a copy of each of which is on file at the office of the Company and made a part hereof as fully as though the provisions of the Operating Agreement were imprinted in full on this Certificate, to all of which the holder of this Certificate, by acceptance hereof, assents.

WITNESS the signature of the duly authorized officer of the Company this ___ day of____, 20__.

_____
Name:
Title: Authorized Signatory

FOR VALUE RECEIVED, THE UNDERSIGNED HEREBY SELLS, ASSIGNS AND TRANSFERS UNTO _____ _____ MEMBERSHIP INTEREST REPRESENTED BY THE WITHIN CERTIFICATE AND DOES HEREBY IRREVOCABLY CONSTITUTE AND APPOINT _____ ATTORNEY TO TRANSFER THE SAID MEMBERSHIP INTEREST ON THE REGISTER OF THE WITHIN NAMED COMPANY WITH FULL POWER OF SUBSTITUTION IN THE PREMISES.

DATED _____

_____

(Signature)

NOTICE: THE SIGNATURE ON THIS ASSIGNMENT MUST CORRESPOND WITH THE NAME AS WRITTEN UPON THE FACE OF THIS CERTIFICATE, IN EVERY PARTICULAR, WITHOUT ALTERATION OR ENLARGEMENT, OR ANY CHANGE WHATEVER.

THE MEMBERSHIP INTEREST REPRESENTED BY THIS CERTIFICATE HAS NOT BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933, AS AMENDED (THE "ACT"), AND HAS BEEN ACQUIRED FOR INVESTMENT AND NOT WITH A VIEW TO, OR IN CONNECTION WITH, THE SALE OR DISTRIBUTION THEREOF. NO SUCH SALE OR DISTRIBUTION MAY BE EFFECTED WITHOUT AN EFFECTIVE REGISTRATION STATEMENT RELATED THERETO OR AN OPINION OF COUNSEL IN A FORM SATISFACTORY TO THE COMPANY THAT SUCH REGISTRATION IS NOT REQUIRED UNDER THE ACT.

THIS CERTIFICATE EVIDENCES AN INTEREST IN PRIME HEALTHCARE SERVICES - LANDMARK, LLC AND SHALL BE A SECURITY FOR THE PURPOSES OF ARTICLE 8 OF THE UNIFORM COMMERCIAL CODE AS IN EFFECT IN THE STATE OF DELAWARE.

Exhibit B

North Smithfield Fire & Rescue Services, Inc.

1470 Providence Pike
North Smithfield, RI 02896

Joel D. Jillson
Fire Chief

Voice (401) 762-1135
Fax (401) 769-2788
Jillson@northsmithfieldfire.com

December 20, 2016

Rhode Island Department of Health
3 Capitol Hill
Providence, RI 02908

To Whom It May Concern:

I respectfully submit this letter of support for Landmark Medical Center, Prime Health Care's Certificate of Need application for Level III Trauma Center designation.

As a 45 year paid professional in the Northern Rhode Island urban & suburban Fire & Rescue service as well as in my current capacity as a sitting Board Governor at Landmark Medical Center, I wholeheartedly endorse the request for this operational modification consistent with all Level III descriptive parameters.

Given Landmarks region of service, the enhanced level of intervention would not only provide a broader spectrum and more in depth delivery of service but as importantly, preclude and or relieve the sole Level I Trauma Center in metro Providence from receiving ALL TRAUMA PATIENTS when often they could and should be seen locally.

With all application mandates being met, I deferentially solicit a favorable outcome of Landmark Medical Centers request for amended designation.

Sincerely,

Joel D. Jillson, Fire & Rescue Chief

TOWN OF BELLINGHAM
Fire Department

STEVEN P. GENTILE, *Chief*
MARK POIRIER, *Deputy*
Telephone: 508-966-1112
Fax: 508-966-5835

Headquarters
28 Blackstone Street
Bellingham, MA 02019

December 28, 2016

Richard Charest, R.PH., MBA

President and CEO

Landmark Medical Center

115 Cass Avenue

Woonsocket, RI 02895

Dear Richard,

I am writing to show support from the Bellingham Fire Department in favor of your process to achieve a Level III trauma Center.

If Rhode Island Department of Health were to grant your application, this would greatly reduce the transport time for critically injured patients from Bellingham and the surrounding towns. Right now, we must travel to Worcester, Boston or call for a Medflight to transport our critically injured. With having a trauma center less than 10 miles away, that would increase a patient's chances of survival tremendously, as you and I are well aware.

Therefore, we here at the Bellingham Fire Department give you our full support in this endeavor and hope for a positive outcome for the people of Southern Massachusetts and Northern Rhode Island.

Sincerely,

Steve Gentile, Fire Chief

Ref. 16-88

Woonsocket Fire Department
5 Cumberland Hill Road
Woonsocket, RI 02895

Paul A. Shatraw
Fire Chief
EMA Deputy Director

Tel. (401) 769-7841
Cell. (401) 692-0975
pshatraw@woonsocketri.org

December 28, 2016

Rhode Island Department of Health
3 Capitol Hill
Providence, RI 02908

To whom it may concern,

I am writing this letter in full support of Landmark Medical Center, Prime Healthcare's application to become a Level III Trauma Center.

As Chief of the Woonsocket Fire Department being home to Landmark Medical Center as well as our service handling over 10,000 calls for service each year I overwhelmingly endorse Landmarks request to upgrade their receiving status to a Level III Trauma Center.

I believe that this upgrade is long overdue. The mere fact that not every trauma incident would have to be transported to a Level I Trauma Center in Providence would be a huge relief to our local service. Trauma patients would receive top notch intervention at much quicker times, out of service times for local services would be significantly reduced, impact on mutual aid providers would be minimized, overall vehicle maintenance would be significantly positively impacted by the shorter transport mileage and relief to the states overburdened Level I Trauma Center would be I'm sure welcomed.

All of my over 35 years in the Fire Service has been spent serving Northern Rhode Island and surrounding Massachusetts communities. The location of Landmark Medical Center serving as a Level III Trauma Center is extraordinary because of its location nestled between Rhode Island and bordering Massachusetts communities that have no avenue to a trauma center without elongated transports to Worcester, Boston or in some cases even Rhode Island Trauma Center.

Please consider Landmark's application and the positive impact that it would have to the Northern Rhode Island area. I certainly endorse and overwhelmingly support the request.

Please contact me should you have any questions or need additional information.

Paul A. Shatraw

Chief of Department

TOWN OF BLACKSTONE
FIRE DEPARTMENT

15 SAINT PAUL STREET
BLACKSTONE, MASSACHUSETTS 01504
PHONE: (508) 883-1030 / FAX: (508) 883-7923

MICHAEL J. SWEENEY
CHIEF

SMOKE DETECTORS SAVE LIVES

January 6, 2017

Please consider this a letter of support for Landmark Medical Center's application to upgrade to a level 3 trauma center. The town of Blackstone fire department operates a paramedic ambulance and borders the city of Woonsocket. The majority of our transports are to Landmark Medical Center with the exception of trauma which we transport to Rhode Island Trauma ten miles away. A full service level 3 trauma center in the northern part of Rhode Island would be a tremendous benefit to many communities in the greater Woonsocket area. This facility would reduce long transport times and out of service time due to the ten mile drive. In addition it will improve our ability to provide better patient care by having trauma patients at an appropriate facility in much shorter times. Our service, like many in this area, has limited options when it involves trauma and this endeavor will be a valuable resource to many communities.

Michael J Sweeney